## Volume II: General Care Practices

# A Study of Care Practices for Persons with Dementia

### in Ontario's Homes for the Aged

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**Volume II: General Care Practices**
**A Study of Care Practices for Persons with Dementia in Ontario's Homes for the Aged**

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## 1.0 INTRODUCTION

### 1.1 Terms of Reference

In 1989, the Elderly Services Branch of Ontario's Ministry of Community and Social Services initiated a comprehensive study of care practices for residents with moderate or severe dementia in Ontario's Homes for the Aged. The terms of reference for the study identified two objectives:

- to describe and compare the range of strategies and techniques used for managing residents with dementia in Ontario's Homes for the Aged; and

- to describe, as a special focus, the role of the special care unit in caring for the elderly with dementia, the unique features of the special care unit, and the experiences in using special care units in Ontario's Homes for the Aged.

In order to meet these objectives, the Flett Consulting Group Ltd., in partnership with Social Data Research Ltd., undertook a study drawing on a survey of general care practices for residents with dementia in Homes for the Aged in Ontario, a parallel survey of special care units within the Homes, and a review of the literature on care practices for elderly persons with dementia. This report, describing the results of the survey of general care practices for residents with dementia in Ontario's Homes for the Aged, is Volume II of a three-volume study. Volume I presents the literature review and Volume III deals with special care units in Ontario's Homes of the Aged.

### 1.2 The Need for the Present Study

An increase in admissions of residents with dementia to Ontario's Homes for the Aged has been observed during recent years as a result of changing patterns of community-based and institutional care. In recognition of the increasing number of elderly persons in Ontario who are choosing to remain in the community rather than seek facility-based care, the Ministry of Community and Social Services has increased the number and range of services supporting seniors in their own homes or the homes of others. With the support of such programs as the Integrated Homemaker Program, the Alzheimer Community Program and the Home Support Program, increasing numbers of seniors are enabled to defer admission to long-term care facilities until the community-based

programs can no longer meet their needs. Compared with seniors admitted to long-term care in the past, these seniors are more likely to have dementia and other health problems requiring assistance at the time they seek admission.

While home support has been helpful for elderly persons with mental health or physical health problems, it has been more effective for persons with physical health problems. Persons with mental health problems often have greater care needs, in many cases requiring continuous supervision. As a result, elderly persons with mental health problems seek facility-based care at a greater rate than persons with physical health problems.

The Ministry of Community and Social Services has recently adopted two measures to enhance the ability of Ontario's Homes for the Aged to care for residents with dementia. The first measure is a $100 million Capital Redevelopment Plan, which has two components: traditional renovations and community residential alternatives.

(1) Under the renovations component of the Capital Redevelopment Plan for Homes for the Aged, at least $66 million is allocated for traditional renovations of outdated facilities.

(2) Under the community residential alternatives component of the Capital Redevelopment Plan for Homes for the Aged, up to $33 million in capital and the necessary operating funds is provided for pilot tests of different types of residential service alternatives. Funding for community residential alternatives is aimed at enabling Homes for the Aged to test alternatives to facility care and increase their capacity in providing supported apartment living in the community.

In addition to the Capital Redevelopment Plan, the Ministry has also initiated this study of care practices in Homes as the foundation for the production and implementation of guidelines for caring for residents with dementia. These guidelines will be developed in consultation with the Homes and will be reviewed in practice, as subsequent phases of this project.

While the question of separate, special care units for residents with dementia has posed philosophical and practical issues in the field, it is not within the scope of this study to make recommendations on this issue or others. Rather, this study serves the larger project best by

providing a clear description of current practices in Ontario's Homes for the Aged and on their special care units.

## 1.3 Orientation to the Survey of General Care Practices

A mail-out survey of all 181 Homes for the Aged in Ontario was conducted in the summer of 1990 to obtain information on residents' characteristics and a description of policies and care practices pertaining to residents with dementia living on general units of the Homes. All Homes were also asked whether they had a separate unit to provide special care for residents with dementia and if so, to complete a second questionnaire concerning the resident profile and care practices and policies on the special care unit. This volume reports on residents' characteristics and the care practices employed with residents with dementia living on general units in Ontario's Homes for the Aged. Volume III of this study reports results of the survey of special care units

## 1.4 Methodology

At the outset of the study, six Homes for the Aged were visited by representatives of the Ministry of Community and Social Services (MCSS) and the consulting firms to learn what kinds of information the Homes record and what other aspects of the Homes' operations would be important in implementing the study. Focus groups were then held with personnel from a cross-section of Homes to clarify issues of concern to the Homes and otherwise assist in designing the questionnaire. At the same time, key researchers in the field of long-term care were asked whether they knew of comparable studies that could provide questions for consideration for the Homes for the Aged questionnaire or that should be included in the literature review.

Development of the general questionnaire and the questionnaire concerning special care units proceeded together, with the latter evolving as a variation of the general questionnaire. Once a first draft had been prepared, a workshop was held with MCSS representatives and specialists in survey design to refine the questionnaires. The questionnaires were revised in subsequent discussions with MCSS and were pretested in the spring of 1990. They were mailed to the administrators of all 181 Homes for the Aged in Ontario in the summer of 1990. Appendix A lists these Homes and Appendix B provides a more detailed description of the methodology used in the survey.

### 1.4.1 Response Rate and Study Bias

Fifteen of the 181 Homes that received questionnaires returned them largely incomplete. When contacted by the study team, the Home personnel indicated they believed the study did not apply to them, in most cases because the Home did not admit residents with dementia. Another four Homes refused to complete the questionnaire because they did not have enough staff time for this purpose. A total of 133 completed returns were received, yielding a response rate of 80% (133/166), adjusting the sample base to remove Homes that did not admit residents with dementia.

Completed questionnaires concerning special care units were received from 67 Homes, in line with expectations that approximately half the Homes would have special care units. Two Homes had two special care units and one Home had three units, resulting in a total of 71 responses.

Response patterns were examined for possible bias. Two questions were of interest here. Would there be under-representation of smaller Homes with fewer staff? Would there be over-representation of municipally-operated Homes compared with charitable Homes? There was no bias by size of the Home; 34% of the Homes in the province have fewer than 100 beds and 34% of the Homes responding to the survey had fewer than 100 beds. However, while 51% of the province's Homes are municipal Homes, about 60% of the Homes that responded to the survey are municipal Homes.

## 1.5 Contents of this Report

The findings of the survey of general care practices are presented in the nine following sections. Section 2.0 presents a profile of the Homes for the Aged in Ontario and their residents. It describes Home residents in terms of age, need for assistance with activities of daily living, and other characteristics. It identifies the proportion of residents with moderate or severe dementia, and compares these residents with the Home's total population.

Section 3.0 discusses the Homes' policies concerning admission of persons with moderate or severe dementia, transfers within the Home, and discharge. Section 4.0 addresses care planning for residents with dementia in terms of reassessment after admission and preparation of care plans.

Differences between care planning for residents with dementia and other residents in the Home are noted.

Features of the physical environment and care practices used to manage residents with dementia are discussed in Section 5.0. Various physical arrangements for residents with dementia are described, along with use of environmental supports and technological aids. Current practices in the Homes concerning use of restraints and management of problem behaviours are also described.

Section 6.0 describes the in-house and outreach programs Homes have developed in response to the needs of their residents with dementia. Section 7.0 discusses staff arrangements, ratios and training related to caring for residents with dementia, along with the role of community resources, specialists, paid companions, volunteers and family. Section 8.0 presents the Homes' perceptions of the costs of caring for residents with dementia.

Section 9.0 discusses Homes' views on special care units, their purpose and perceived advantages. The respondent group included Homes that have special care units and Homes that do not have these units. The final section presents the Homes' perceptions of their role in the future in terms of meeting the needs of elderly persons with dementia.

## 2.0 DESCRIPTION OF HOMES AND CHARACTERISTICS OF RESIDENTS IN ONTARIO'S HOMES FOR THE AGED

A detailed description of the Homes and their residents' characteristics was an important part of the survey because it indicates the number of residents with moderate or severe dementia in the Homes.

### 2.1 Description of Homes

Respondents were asked to describe their Homes in terms of the number of residents, number and types of approved beds, number and types of rooms, and to indicate whether the Home is accredited or will be accredited.

#### 2.1.1 Number of Residents

Exhibit 2.1.1 shows the wide range in the size of the 131 Homes for the Aged providing this information. While more than one quarter (28.2%; N=37) of the Homes have between 50 and 99 residents, the majority (62.5%; N=82) reported more than 100 residents. Just less than 10% (9.2%; N=12) had fewer than 50 residents and nine Homes (6.9%) reported having more than 300 residents.

#### 2.1.2 Number and Types of Beds

The Homes reported an average[1] of 142 approved beds, including residential and extended beds. The largest Home had 447 approved beds; the smallest had four beds. The proportion of residential[2] and extended[3] care beds in each Home varied considerably. In the average or "typical"[1] Home, about 40% of all approved beds are reserved for residential care and about 60% are reserved for extended care beds. About half (52.3%; N=69) of the Homes have in the range of 25% to 49% residential care beds (Exhibit 2.1.2).

The majority of Homes in the study (73.3%; N=96) do not have any respite care[4] beds. Of those that do, the number of beds set aside for respite care ranges from one to about six.

EXHIBIT 2.1.1

## Number of Residents in Ontario's Homes for the Aged

| *Number of Residents* | *Number of Homes* | *Per Cent* |
|---|---|---|
| Less than 50 | 12 | 9.2 |
| 50-99 | 37 | 28.2 |
| 100-149 | 25 | 19.1 |
| 150-199 | 24 | 18.3 |
| 200-249 | 18 | 13.7 |
| 250-299 | 6 | 4.5 |
| 300 or more | 9 | 6.9 |
| **Total** | **131** | **100.0** |

Number of Missing Observations = 2

EXHIBIT 2.1.2

## Distribution of Approved Bed Type in Ontario's Homes For the Aged

| ***Proportion of Beds in Home Which Are Residential:*** | *Number of Homes* | *Per Cent* |
|---|---|---|
| 0% | 1 | <1.0 |
| 1-24% | 23 | 17.4 |
| 25-49% | 69 | 52.3 |
| 50-74% | 20 | 15.2 |
| 75% or more | 19 | 14.4 |
| **Total** | **132** | **100.0** |

| ***Proportion of Beds in Home Which Are Extended:*** | | |
|---|---|---|
| 0% | 1 | 12.1 |
| 1-24% | 4 | 3.0 |
| 25-49% | 20 | 15.2 |
| 50-74% | 69 | 52.3 |
| 75% or more | 23 | 17.4 |
| **Total** | **132** | **100.00** |

Number of Missing Observations = 1

### 2.1.3 Number and Types of Rooms

The number of rooms per Home ranges from six or less to 232, with the typical Home having about 77 rooms. Eleven Homes offer no private rooms and almost half (48.8%; N=62) of the Homes have rooms that accommodate three or more persons. Most Homes (94.5%; N=120) have double rooms.

### 2.1.4 Accreditation

When asked if Homes were accredited, just over 40% (41.4%; N=55) of the respondents said they were, most in the last year or two. While 13 non-accredited Homes have no plans to be accredited, the other non-accredited Homes expect to be accredited, most in the next two or three years.

## 2.2 Characteristics of the Residents

Respondents were asked to describe their residents in terms of age and gender, marital status, the degree to which they needed assistance with activities of daily living, ambulation abilities, and the extent of cognitive impairment, if any. In order to assist respondents in this task, two sets of work sheets were developed - the first to summarize the information on all residents, including those with and without dementia, and the second to summarize information on residents with moderate or severe dementia (described in Section 2.3). The figures provided by each Home in the various categories were summed to create provincial data.

### 2.2.1 Age and Sex

Most of the residents in Ontario's Homes for the Aged are women. Almost three quarters (72%) of residents described by all respondents are female. Profiles of individual Homes also showed the majority of residents are female and only about 5% (4.6%; N=6) of the Homes in the study reported that the majority of their residents are male.

Exhibit 2.2.1 presents the age distribution of residents across all Homes in the study. Almost half (49.4%) of the residents are 85 years of age or older. Very few (2.7%) are under the age of 65,

EXHIBIT 2.2.1

# Age Distribution of Residents in Ontario's Homes for the Aged

| *Age Group* | *Number of Residents* | *Per Cent* |
|---|---|---|
| Under 60 years of age | 165 | 0.8 |
| 60-64 years of age | 363 | 1.9 |
| 65-74 years of age | 2,161 | 11.1 |
| 75-84 years of age | 7,189 | 36.8 |
| 85-94 years of age | 8,305 | 42.5 |
| 95 years of age or older | 1,345 | 6.9 |

Number of Homes Responding = 131
Number of Missing Observations = 2

although 40% of the Homes report having at least one resident under the age of 60; and 60% have at least one resident between the ages of 60 and 64.

### 2.2.2 Marital Status

As Exhibit 2.2.2 demonstrates, most residents (86.2%) are single, and many are widowed. Of the married residents, almost an equal proportion have spouses living in the same Home (6.3%) as elsewhere (7.5%) in the community. Eighteen Homes (13.7%) reported having no couples in their facility.

### 2.2.3 Assistance with Activities of Daily Living

Respondents were asked to indicate how many residents required help with activities of daily living such as bathing, dressing, toiletting, transferring from bed to chair, continence, and feeding. Exhibit 2.2.3 shows that half (50.3%) of all residents require staff help with three or more of these activities on a daily basis. Only 14% need no help at all.

Nineteen Homes reported that all of their residents need help with activities of daily living. In fact, almost all Homes responding to this question (96.2%; N=126) have at least one resident who requires help with three or more activities of daily living.

### 2.2.4 Ambulation

Exhibit 2.2.4 shows the proportions of residents in the Homes by their degree of ambulatory independence. More than one third (38.2%) of residents are independently mobile without the need of an assistive aid such as a cane or walker.

At the other extreme, almost one quarter (24.2%) of all residents are mobile only with staff assistance. Only 13 Homes in the study reported that all of their residents are mobile, with or without aids. Almost 20% (19.1%; N=31) of respondents said that about one third or more of their residents are not mobile unless they have staff assistance.

EXHIBIT 2.2.2

## Marital Status of Residents in Ontario's Homes for the Aged

| *Marital Status* | *Number of Residents* | *Per Cent* |
|---|---|---|
| Single | 16,668 | 86.2 |
| Married with spouse living elsewhere | 1,447 | 7.5 |
| Married with spouse living in same Home | 1,204 | 6.3 |

Number of Homes Responding = 133

EXHIBIT 2.2.3

## Amount of Assistance with Activities of Daily Living[1] Needed by Residents in Ontario's Homes for the Aged

| *Amount of Assistance Needed* | *Number of Residents* | *Per Cent* |
|---|---|---|
| No assistance needed | 2,593 | 14.0 |
| Assistance needed with one or two activities | 6,626 | 35.7 |
| Assistance needed with three or more activities | 9,345 | 50.3 |

Number of Homes responding = 132
Number of Missing Observations = 1

[1] Activities included bathing, dressing, toiletting, transferring from bed to chair, continence, feeding.

EXHIBIT 2.2.4

# Degree of Ambulation of Residents in Ontario's Homes for the Aged

| *Degree of Ambulation* | *Number of Residents* | *Per Cent* |
|---|---|---|
| Residents who are independently mobile without cane or walker | 7,429 | 38.2 |
| Residents who are independently mobile with a cane or walker | 4,284 | 22.0 |
| Residents who use a wheelchair | 3,027 | 15.6 |
| Residents who are mobile only with staff assistance | 4,703 | 24.2 |

Number of Homes Responding = 133

### 2.2.5 Cognitive Impairment

Respondents were asked to record the numbers of residents in their Home who had no dementia and the number with mild, moderate or severe dementia. A standard set of criteria (shown in Exhibit 2.2.5.1) for each level of impairment was provided in the questionnaire and in a separate attachment to the questionnaire.

As Exhibit 2.2.5.2 shows, fully two thirds (66.6%) of residents in the Homes that responded to the survey are judged by staff to have some form of dementia using a standard classification (Exhibit 2.2.5.1). More than 40% (40.8%) of the residents in the responding Homes are perceived to have moderate or severe forms of dementia. Only 17.5% of the residents, however, have an actual diagnosis of Alzheimer's disease or a related dementia on their chart.

There is a direct relationship between the number of residents with dementia and the size of Home. Exhibit 2.2.5.3 reveals that the Homes with a larger number of residents have a considerably higher proportion of residents that staff believe have moderate or severe dementia, compared with smaller Homes. Over half (51.9%) of the residents in Homes with more than 300 residents were reported to have moderate or severe forms of dementia, compared to only 14% of residents in Homes with fewer than 50 residents.

## 2.3 Characteristics of Residents with Moderate or Severe Dementia

The Homes were asked to describe their residents with moderate or severe dementia in terms of the same characteristics used to describe the resident population as a whole. Some selected comparisons between the resident population as a whole, described above, and residents with moderate or severe dementia are presented in this section. Fourteen Homes reported that they did not have any residents with moderate or severe dementia, according to the classification (see Exhibit 2.2.5.1) provided and thus were not included in many of the analyses. In a few other instances, respondents were not able to provide a breakdown of some of these characteristics for residents with moderate or severe dementia.

EXHIBIT 2.2.5.1

# Definitions of Levels of Cognitive Impairment Used to Classify Residents with Mild, Moderate or Severe Dementia in Ontario's Homes for the Aged

**Level 0** — Number of residents who have **no cognitive impairment/dementia** (i.e. are fully oriented to time, person and place).

**Level 1** — Number of residents who have **mild dementia** characterized by loss of memory and learning abilities with preservation of feeling, perception and movement. Resident needs: can function without direction only in familiar surroundings and by virtue of environmental cues. (Minimum supervision is required.)

**Level 2** — Number of residents with **moderate dementia** characterized by pronounced loss of memory and moderate impairment of psychomotor and neurological functioning. Resident needs: can follow some verbal direction but needs assistance with dressing, hygiene and safeguarding of personal effects. Residents may exhibit a range of behaviours such as wandering, sexual disinhibition etc. (24-hour supervision is required.)

**Level 3** — Number of residents with **severe dementia** characterized by profound loss of all higher mental functions. Resident needs: personal care is totally assisted by a care provider and incontinence is often present. Residents are often immobile and the emphasis is on physical care. (24-hour supervision and care are required.)

EXHIBIT 2.2.5.2

## Level of Dementia of Residents in Ontario's Homes for the Aged

| *Level of Dementia* | *Number of Residents* | *Per Cent* |
|---|---|---|
| No dementia | 6,456 | 33.4 |
| Mild dementia | 4,992 | 25.8 |
| Moderate dementia | 3,906 | 20.2 |
| Severe dementia | 3,977 | 20.6 |

Number of Homes Responding = 133

EXHIBIT 2.2.5.3

## Per Cent of Residents with Moderate or Severe Dementia by Total Number of Residents in Home

| ***Total Number of Residents In Home*** | *Per Cent of Residents with Moderate or Severe Dementia* |
|---|---|
| Less than 50 residents | 14.0 |
| 50-99 residents | 31.6 |
| 100-149 residents | 36.3 |
| 150-199 residents | 36.8 |
| 200-249 residents | 47.5 |
| 250-299 residents | 47.6 |
| 300 or more residents | 51.9 |

Number of Homes Responding = 131
Number of Missing Observations = 2

### 2.3.1 Age, Sex and Marital Status of Residents with Moderate or Severe Dementia

In terms of the age and sex distribution, there is very little difference between all residents and residents classified by the Homes as having moderate or severe dementia. Slightly more than half (54.4%) of residents with moderate or severe dementia are over the age of 85; about one third (34.8%) are between the ages of 75 and 84, and just over 10% (10.8%) are younger. This distribution is almost identical to the one presented in Exhibit 2.2.1 for the resident population as a whole. About one quarter (24.4%) of the residents with moderate or severe dementia are males, the same proportion as in the resident population as a whole.

Just as in the resident population as a whole, most residents with moderate or severe dementia are single (84.1%). Slightly over 10% (11.3%) are married with spouses living elsewhere. Only 4.6% are married with a spouse also living in the Home, a somewhat lower proportion than that reported for all residents (6.3%).

### 2.3.2 Living Arrangements One Year Ago of Residents with Moderate or Severe Dementia

Respondents were asked where the residents with moderate or severe dementia were living one year prior to the survey. As Exhibit 2.3.2 shows, most of these residents (73.8%) were living on the same ward one year ago. About 12% (11.8%) were living elsewhere in the Home and almost 7% (6.8%) were living with family. Very few were staying in a chronic care facility (1.2%), living alone in the community (3.1%), or residing in another long term care facility for seniors (3.3%).

### 2.3.3 Difficulties with Activities of Daily Living for Residents with Moderate or Severe Dementia

Differences between the resident population as a whole and those with moderate or severe dementia can be clearly seen in the assistance required with the activities of daily living described earlier in 2.2.3. **Almost all residents (97.1%) with moderate or severe dementia in the Homes who responded to the survey need help with three or more activities of daily living.** Only half (50.3%) of the resident population as a whole requires this level of assistance.

EXHIBIT 2.3.2

## Living Arrangements One Year Ago of Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged

| *Living Arrangements* | *Number of Residents* | *Per Cent* |
|---|---|---|
| Same ward | 5,718 | 73.8 |
| Elsewhere in Home | 914 | 11.8 |
| Living with family | 524 | 6.8 |
| Living alone in the community | 244 | 3.1 |
| Staying in another long term care facility | 257 | 3.3 |
| Staying in a chronic care facility | 91 | 1.2 |

Number of Homes Responding = 118
Number of Missing Observations (Not Applicable/Don't Know) = 15

### 2.3.4 Ambulation for Residents with Moderate or Severe Dementia

Respondents reported major differences in the ambulation ability of the resident population as a whole and residents with moderate or severe dementia. **Twice as many residents with moderate or severe dementia require staff assistance to be mobile, with 43.5% of these residents requiring staff assistance, compared with 24.2% of all residents as a whole.** Residents with moderate or severe dementia are also twice as likely to use a cane or walker (22.0% vs. 11.4%). The proportion of residents with moderate or severe forms of dementia who are independently mobile without assistance of any kind is just slightly lower than for the resident population as a whole (33.5% vs. 38.2%) as is the proportion of wheelchair users (11.6% vs. 15.6%).

### 2.3.5 Problem Behaviours of Residents with Moderate or Severe Dementia

Exhibit 2.3.5 presents the proportions of residents with moderate or severe dementia who display various common problem behaviours. Incontinence is the most common problem behaviour, as defined by respondents, and is experienced by almost two thirds (61.9%) of residents with moderate or severe dementia. Almost half (47.4%) of these residents display agitation through pacing or continual chatting. Abusive or aggressive behaviour as well as wandering is attributed to more than one quarter (29.4% and 29.3% respectively) of the residents with moderate or severe dementia, and hoarding or rummaging is common among just over 15% (17.5%) of residents.

Respondents also listed a variety of other behaviours displayed by almost 20% (18.6%) of residents with moderate or severe dementia. Included on this list were refusal to eat or drink, undressing inappropriately, unhygienic practices and sexually aggressive behaviours.

EXHIBIT 2.3.5

## Problem Behaviours of Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged

| *Problem Behaviours* | *Number of Residents* | *Per Cent* |
|---|---|---|
| Incontinence | 4,883 | 61.9 |
| Agitation (pacing, chatting) | 3,740 | 47.4 |
| Abusive or aggressive | 2,315 | 29.4 |
| Wandering | 2,313 | 29.3 |
| Hoarding, rummaging | 1,381 | 17.5 |
| Other behaviours (i.e. refusal to eat or drink, undressing, unhygienic practices, sexually aggressive) | 1,465 | 18.6 |

Number of Homes Responding = 117
Number of Missing Observations (Not Applicable/Don't Know) = 16

## 3.0 ADMISSION, TRANSFER AND DISCHARGE POLICIES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

The following section describes the Homes' admission, transfer and discharge policies and procedures for residents with moderate or severe dementia. In interpreting the findings, it is important to note that respondents were asked to provide answers to these questions as they pertain to residents with moderate or severe dementia **living outside a special or separate care unit**, if the Home had a unit.

### 3.1 Admission Policies

At least 12 Homes indicated they did not admit people with dementia and thus excluded themselves from these questions and most of the subsequent items related to transfer and discharge policies. The Homes responding to the survey that admitted applicants with moderate or severe dementia indicated a range of 1 to 59 admissions during the last 12 months. Most Homes, however, have admitted fewer than 12 residents with moderate or severe dementia during this time period. Seventy five per cent (N=90) of Homes had a current waiting list for these residents.

#### 3.1.1 Admission Criteria

In order to determine the types of admission criteria and procedures used by Homes for the Aged in Ontario for applicants with moderate or severe dementia, respondents were presented with a list of possible criteria and asked to indicate whether or not these criteria were employed in their Home. These criteria and the proportion and number of Homes that included them in their admission policy are as follows:

- *Home can provide care needed (87.4%; N=104).*
- *Home has available space (84.0%; N=100).*
- *Services in community no longer meet need (77.3%; N=92).*
- *Applicant shows no or only mild aggression (67.2%; N=80).*
- *Applicant is compatible with other residents (63.0%; N=75).*
- *Applicant displays wandering behaviour (55.9%; N=66).*

About 10% (10.1%; N=12) of respondents gave other answers, most frequently indicating that they have no restrictions.

### 3.1.2 Pre-admission Assessment

Respondents were asked who conducts applicant assessments prior to admission. Most Homes said that the applicant's physician (78.9%; N=90) and the medical director of the Home (74.4%; N=87) usually conduct the assessment. (See Exhibit 3.1.2.1.) Placement coordination services, where they exist, are usually involved in just over half (56.5%; N=48) of the Homes. Chronic or acute care hospitals are usually not involved. In response to an open-answer question, some Homes volunteered that the following were involved in pre-admission assessments: nurses, the Home's administrator, a social worker, a geriatric assessment unit, and a home support coordinator.

The level of satisfaction with several defined aspects of the pre-admission assessment was determined by asking respondents to rate how they felt about each aspect on a scale of 1 to 5, where 1 was "very satisfied" and 5 was "very dissatisfied". The mean scores are given in Exhibit 3.1.2.2. None of the Homes were very satisfied. In fact, the most positive score is 2.5 for the respondents' opinions about the "accuracy in indicating appropriate placement". Respondents are the most dissatisfied with the "accuracy of information provided by family" (3.0).

### 3.1.3 In-Home Admission Assessments

Respondents were also asked about participants in in-Home admission assessments and other aspects of the assessment. As Exhibit 3.1.3 shows, staff usually involved in in-Home assessments upon admission of residents with moderate or severe dementia are the social worker (85.1%; N=40) and the head nurse (80.4%; N=41), in those Homes that had these positions. Other staff usually involved in the majority of Homes are the unit or ward supervisor (78.6%; N=33), the director of nursing (75.0%; N=75), the medical director (74.5%; N=73), other registered nursing (R.N.) staff members (69.0%; N=58), family members (68.4%; N=65), the dietician (64.8%; N=57), a health care assistant (H.C.A.)/orderly (63.7%; N=58), a registered nursing assistant (R.N.A.) staff member (60.8%; N=45) and an adjuvant (60.2%; N=53).

Just over half the Homes (57.0%; N=49) said the family physician usually participates in the in-Home assessments upon admission of residents with moderate or severe dementia, and less than half

EXHIBIT 3.1.2.1

# Persons/Services Involved in Pre-admission Assessment of Applicants with Moderate or Severe Dementia by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Conducts Pre-admission Assessments*

| ***Persons/Services*** | Usually Conducts | | Sometimes Conducts | | Never Conducts | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Resident's Physician | 78.9 | 90 | 11.4 | 13 | 9.7 | 11 | 19 | 6 |
| Medical Director of Home | 74.4 | 87 | 17.9 | 21 | 7.7 | 9 | 16 | 3 |
| Placement Coordination Service | 56.6 | 48 | 25.9 | 22 | 17.5 | 15 | 48 | 11 |
| Chronic or Acute Care Hospital | 18.5 | 20 | 62.0 | 67 | 19.5 | 21 | 25 | 15 |

EXHIBIT 3.1.2.2

## Level of Satisfaction with the Pre-admission Assessments as They Affect Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

**Based on the Mean Score of Responses, Where 1 = Very Satisfied and 5 = Very Dissatisfied.**

| ***Aspect of Pre-admission Assessment*** | Mean Score | Number of Homes Responding | Number of Missing Observations | |
|---|---|---|---|---|
| | | | *Not App.* | *Don't Know* |
| Accuracy in indicating appropriate placement | 2.5 | 113 | 15 | 5 |
| Number of professional disciplines involved | 2.6 | 113 | 15 | 5 |
| Content of assessment | 2.7 | 112 | 15 | 6 |
| Time period between assessment and admission | 2.8 | 113 | 15 | 5 |
| Adequacy of the assessment tools used | 2.8 | 111 | 15 | 7 |
| Accuracy of information provided by family physicians and other professionals | 2.9 | 112 | 15 | 6 |
| Accuracy of information provided by families | 3.0 | 112 | 15 | 6 |

EXHIBIT 3.1.3

## Persons Involved in In-Home Admission Assessment of Applicants with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Conducts In-Home Admission Assessments*

| Persons | Usually Conducts | | Sometimes Conducts | | Never Conducts | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | N | % | N | % | N | Not Applicable | Don't Know |
| Social worker | 85.1 | 40 | 10.6 | 5 | 4.3 | 2 | 75 | 11 |
| Head nurse | 80.4 | 41 | 13.7 | 7 | 5.9 | 3 | 75 | 7 |
| Unit/ward supervisor | 78.6 | 33 | 11.9 | 5 | 9.5 | 4 | 78 | 13 |
| Director of nursing | 75.0 | 75 | 17.0 | 17 | 8.0 | 8 | 27 | 6 |
| Medical director | 74.5 | 73 | 19.4 | 19 | 6.1 | 6 | 26 | 9 |
| Other R.N. staff | 69.0 | 58 | 19.0 | 16 | 11.9 | 10 | 38 | 11 |
| Family members | 68.4 | 65 | 30.5 | 29 | 1.1 | 1 | 27 | 11 |
| Dietician | 64.8 | 57 | 22.7 | 20 | 12.5 | 11 | 38 | 7 |
| H.C.A./orderly | 63.7 | 58 | 17.6 | 16 | 18.7 | 17 | 32 | 10 |
| R.N.A. staff | 60.8 | 45 | 20.3 | 15 | 18.9 | 14 | 49 | 10 |
| Adjuvant | 60.2 | 53 | 22.7 | 20 | 17.0 | 15 | 36 | 9 |
| Resident's physician | 57.0 | 49 | 17.4 | 15 | 25.6 | 22 | 36 | 11 |
| Administrator | 45.4 | 44 | 24.7 | 24 | 29.9 | 29 | 28 | 7 |

(45.4%; N=44) indicated that the Home's administrator is usually involved. A few respondents volunteered other types of participants not provided on the original list, including recreation coordinators, housekeepers and resident services coordinators.

*Content of In-Home Admission Assessments*

Almost all Homes said they assess the resident's ability to conduct activities of daily living (99.1%; N=108) and compile the resident's social or family history (96.3%; N=105) upon admission. Other components of the in-Home assessment include a comprehensive medical examination (89.0%; N=97), a mental status evaluation (67.0%; N=73) and a psychological profile (59.6%; N=65). About 24 Homes listed other items in their assessment, such as a level of care scale, an adjuvant assessment, a visit to the resident's home, a dietary assessment, and a physiotherapy assessment.

*Use of Formal Assessment Tools*

Two thirds (66.1%; N=72) of the Homes said they use at least one structured or formal assessment tool. The most frequently cited instrument was the Folstein Mini-Mental State Examination.

*Representation of Applicants*

Since many applicants with moderate or severe dementia may not be able to speak for themselves, respondents were asked if their Home usually assigned someone (formally or otherwise) to represent these applicants. Almost all Homes said yes (95.0%; N=113), indicating another family member as the usual designate (92.9%; N=79). In some cases (43.4%; N=49), but not usually (29.2%; N=33), a person holding power of attorney, other than family is assigned.

### 3.1.4 Sources of Referrals

Homes for the Aged in Ontario receive referrals from many sources. Exhibit 3.1.4 presents a list of possible referral sources and the number of respondents indicating they received referrals for residents with moderate or severe dementia from this source. Family members are the most common source (91.5%; N=108) followed by local hospitals (85.6%; N=101), a placement coordination service (85.6%; N=77) in those communities that had them, and the client's own

EXHIBIT 3.1.4

# Source of Referrals for Applicants with Moderate or Severe Dementia in Ontario's Homes for the Aged

*Percent and Number of Homes Who Indicate Source Is Available and Applicants Are Received through Source*

| ***Persons*** | Available/Applicable in Community | | Receive Applicants | | Number of Missing Observations |
|---|---|---|---|---|---|
| | % | *N* | % | *N%* | *Not Applicable/ Don't Know* |
| Family members | 88.7 | 118 | 91.5 | 108 | 15 |
| Placement coordination | 67.7 | 90 | 85.6 | 77 | 43 |
| Local hospitals | 88.7 | 118 | 85.6 | 101 | 15 |
| Client's physician | 88.7 | 118 | 83.9 | 99 | 15 |
| Other long term care facilities | 87.2 | 116 | 68.1 | 79 | 17 |
| Self referral | 70.7 | 94 | 63.8 | 60 | 39 |
| Local home care program | 85.7 | 114 | 51.8 | 59 | 19 |
| Public health nurse | 88.0 | 117 | 41.0 | 48 | 16 |
| Home support agency | 81.2 | 108 | 32.4 | 35 | 25 |
| Alzheimer's Society | 81.2 | 108 | 22.2 | 24 | 25 |
| Homemakers agency | 85.0 | 113 | 16.8 | 19 | 20 |
| Integrated Homemakers Program | 78.2 | 104 | 16.3 | 17 | 29 |
| Community information service | 75.2 | 100 | 14.0 | 14 | 33 |
| Local Association for Community Living/Association for the Mentally Retarded | 85.7 | 114 | 9.6 | 11 | 19 |
| Private nursing service | 80.5 | 107 | 9.3 | 10 | 26 |
| Seniors' council/organization | 78.9 | 105 | 2.9 | 3 | 28 |

physician (83.9%; N=99). Less common, but still indicated by the majority of Homes as a possible referral source, are other long term care facilities (68.1%; N=79) and self referral (63.8%; N=60).

For each of the possible referral sources listed in Exhibit 3.1.4, respondents were asked to rank the top three sources in terms of the number of referrals for applicants with moderate or severe dementia. Only three sources were ranked in the top three by most Homes which indicated receiving any referrals from this source. These sources are family members (84.3%; N=91), local hospitals (79.2%; N=80) and the placement coordination service (66.2%; N=51) (in those communities that had one).

### 3.1.5 Barriers to Admission

Respondents were asked to review a list of 10 commonly cited barriers to admission of residents with moderate or severe dementia and indicate whether these barriers were experienced by applicants to their Home. Barriers indicated most frequently are (per cent and number of Homes given in brackets):

- *no vacant beds in the Home for the level of care required by applicant (87.4%; N=104);*
- *applicant's resistance to admission (69.7%; N=83);*
- *home not designed to care for resident (66.6%; N=80);*
- *insufficient staff for the level of care required by applicant (64.7%; N=77).*

Almost 90% (87.5%; N=91) of all Homes which chose "no vacant beds" as a barrier, ranked it as one of the top three barriers to admission faced by applicants with moderate or severe dementia. "Home not designed for care" (80.0%; N=64) and "insufficient staff" (81.2%; N=63) were also ranked in the top three by many of the Homes.

## 3.2 Transfer Policies

This section discusses transfer policies and procedures exercised by Homes for the Aged in the study, for residents with moderate or severe dementia living outside a special care unit.

### 3.2.1 Transfer Criteria and Decision Making

Respondents were asked to indicate whether or not a list of five criteria were used to determine if a resident with moderate or severe dementia is transferred within the Home. The per cent and number of Homes indicating they use each of the criteria are listed below:

- *Resident wanders outside the Home (93.4%; N=113).*
- *Resident displays extreme aggression (88.5%; N=100).*
- *Resident requires a more structured environment (81.2%; N=99).*
- *Resident wanders within the Home (62.8%; N=76).*
- *Resident becomes immobile (58.7%; N=71).*

Additional criteria were volunteered by about 13 respondents, and included "physical deterioration of resident", "resident requires more care" and "resident harassed by peers".

Exhibit 3.2.1 lists the person(s) involved in transfer decisions concerning residents with moderate or severe dementia, beginning with the person(s) indicated most frequently by the Homes. Respondents indicated that the head nurse (96.5%; N=55) or the unit or ward supervisor (96.0%; N=48) (in Homes that had these positions) usually makes the decision to transfer, followed very closely by the director of nursing (89.0%; N=105) and family members (86.0%; N=98).

### 3.2.2 Barriers to Transfer

The questionnaire listed some commonly-cited barriers to the transfer of residents with moderate or severe dementia within a Home and asked respondents to indicate which of the barriers were experienced by residents in their Home. In order of the per cent and number of respondents who acknowledged each barrier, they are:

- *no vacant beds in the Home for the level of care required by resident (90.8%; N=109);*
- *family's resistance to transfer (79.2%; N=95);*
- *resident's resistance to transfer (72.5%; N=87);*
- *Home not designed to care for resident (58.3%; N=70);*

EXHIBIT 3.2.1

## Persons Involved in Transfer Decisions of Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

| Persons | *Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Involved in Transfer Decisions* | | | | | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | Usually Involved | | Sometimes Involved | | Never Involved | | | |
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Head nurse | 96.5 | 55 | 3.5 | 2 | 0.0 | 0 | 68 | 8 |
| Unit/ward supervisor | 96.0 | 48 | 4.0 | 2 | 0.0 | 0 | 69 | 14 |
| Director of nursing | 89.0 | 105 | 11.0 | 13 | 0.0 | 0 | 12 | 3 |
| Family members | 86.0 | 98 | 14.0 | 16 | 0.0 | 0 | 13 | 6 |
| Other R.N. staff | 70.2 | 73 | 27.9 | 29 | 1.9 | 2 | 19 | 10 |
| Resident's physician | 66.3 | 67 | 27.7 | 28 | 5.9 | 6 | 25 | 7 |
| Medical director | 63.8 | 74 | 31.0 | 36 | 5.2 | 6 | 12 | 5 |
| Social worker | 67.9 | 36 | 18.9 | 10 | 13.2 | 7 | 68 | 12 |
| Administrator | 62.4 | 73 | 31.6 | 37 | 6.0 | 7 | 12 | 4 |
| H.C.A./orderly | 58.7 | 64 | 29.4 | 32 | 11.9 | 13 | 15 | 9 |
| R.N.A. staff | 53.5 | 46 | 33.7 | 29 | 12.8 | 11 | 37 | 10 |
| Adjuvant | 32.0 | 31 | 43.3 | 42 | 24.7 | 24 | 21 | 15 |
| Dietician | 24.4 | 18 | 38.1 | 32 | 40.5 | 34 | 31 | 18 |

- *uncertainty among staff about best placement (57.5%; N=69);*
- *Home cannot accommodate couples (14.2%; N=17).*

Respondents were also instructed to rank the top three barriers in terms of how frequently they are experienced. Almost two thirds (64.2%; N=71) ranked the lack of beds for the level of care required by residents with moderate or severe dementia as the one outstanding barrier to transfer.

Quite a variety of responses were given to a question concerning what changes, if any, respondents would recommend in transfer procedures. The one that was volunteered the most, however, was "to be able to spend more time with family or provide more family support". Some Homes also said they would prefer it if residents did not have to move. Others wanted more private rooms or other facility-related changes.

## 3.3 Discharge Policies

Several questions were posed with respect to discharge policies and procedures for residents with moderate or severe dementia living outside a special care unit (if the Home has one). The Homes' responses to these questions are presented below.

### 3.3.1 Reasons for Discharge

Respondents were asked to indicate the first, second and third most frequent reason for the discharge of residents with moderate or severe dementia (other than death), choosing from a list of possible reasons. The reason ranked among the top three by most respondents was that the "resident requires specialized psychiatric care (74.4%; N=90), followed by "resident displays violent behaviour" (71.9%; N=87) and "resident requires more care than the Home can provide" (53.7%; N=71). (See Exhibit 3.3.1.)

### 3.3.2 Staff Involvement in Discharge Decisions

Unlike decisions related to admission and transfer, the resident's physician plays a much more prominent position in the discharge decision for residents with moderate or severe dementia. As shown in Exhibit 3.3.2, many Homes (89.3%; N=92) indicated that the physician is usually

EXHIBIT 3.3.1

## The Three Highest Ranked Reasons (Other than Death) for Discharging Residents with Moderate or Severe Dementia Living Outside Special Care Units

*Per Cent and Number of Homes Who Rank Reason as First, Second or Third Most Frequent Reason*

| ***Reason*** | *Per Cent* | *Number* |
|---|---|---|
| Resident requires specialized psychiatric care | 74.4 | 90 |
| Resident displays violent behaviour | 71.9 | 87 |
| Resident has an acute illness | 53.7 | 65 |
| Family requests another facility or community option | 24.8 | 30 |
| Resident has chronic condition | 18.2 | 22 |

Number of Homes Responding = 121
Number of Missing Observations (Not Applicable) = 12

EXHIBIT 3.3.2

## Persons Involved in Discharge Decisions of Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Involved in Discharge Decisions*

| ***Persons*** | Usually Involved | | Sometimes Involved | | Never Involved | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Family members | 94.6 | 105 | 5.4 | 6 | 0.0 | 0 | 15 | 7 |
| Director of nursing | 91.5 | 107 | 7.7 | 9 | 0.8 | 1 | 13 | 3 |
| Head nurse | 91.1 | 51 | 8.9 | 5 | 0.0 | 0 | 67 | 10 |
| Resident's physician | 89.3 | 92 | 8.7 | 9 | 1.9 | 2 | 23 | 7 |
| Unit/ward supervisor | 84.8 | 39 | 10.9 | 5 | 4.3 | 2 | 71 | 16 |
| Medical director | 83.5 | 96 | 16.5 | 19 | 0.0 | 0 | 13 | 5 |
| Social worker | 77.4 | 41 | 13.2 | 7 | 9.4 | 5 | 68 | 12 |
| Administrator | 77.1 | 91 | 19.5 | 23 | 3.4 | 4 | 13 | 2 |
| Other R.N. staff | 58.0 | 58 | 37.0 | 37 | 5.0 | 5 | 19 | 14 |
| H.C.A./orderly | 40.6 | 41 | 27.7 | 28 | 31.7 | 32 | 17 | 15 |
| R.N.A. staff | 35.8 | 29 | 38.3 | 31 | 25.9 | 21 | 36 | 16 |
| Adjuvant | 27.5 | 25 | 31.9 | 29 | 40.7 | 37 | 23 | 19 |
| Dietician | 17.0 | 14 | 18.3 | 15 | 64.6 | 53 | 30 | 21 |

involved in the process. Family members, however, are also usually involved in the discharge decision, according to most Homes (94.6%; N=105), followed by the director of nursing (91.5%; N=107). Almost as frequently mentioned is the head nurse (91.1%; N=51).

## 4.0 CARE PLANNING FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

Homes were asked a series of questions about their reassessment procedures and care planning strategies for residents with moderate or severe dementia living outside special care units. In some instances, respondents were requested to make comparisons with residents without moderate or severe dementia.

### 4.1 Reassessment

Almost all Homes (93.3%; N=111) which admitted residents with moderate or severe dementia reported reassessing these residents more than once a year. In fact, 10% (N=11) of the Homes make monthly reassessments. Most Homes (82.8%; N=91), however, carry out no more than four reassessments annually.

Only two Homes said that they reassess residents with moderate or severe dementia less often than those without moderate or severe dementia. Just over half (54.9%; N=67) of the responding Homes reported the same number of reassessments for both types of residents, and about 40% (40.2%; N=49) reassess residents with moderate or severe dementia more often than other residents. The major reason given for this difference is that reassessment is necessary to monitor and deal with behaviour problems when the need arises.

Exhibit 4.1 shows the persons usually involved in the reassessment process for residents with moderate or severe dementia living outside special care units. If the Home has a head nurse and/or a unit or ward supervisor (which less than half the responding Homes do), these staff persons are usually involved in the reassessment process (96.4%; N=53 and 95.9%; N=47, respectively). Other key staff persons, according to the respondents who have these staff, are social workers (78.3%; N=36) and other R.N. staff members (77.9%; N=81).

About half the Homes (50.4%; N=58) report that family members are usually involved in the reassessment of residents with moderate or severe dementia. Those persons generally not involved include the administrator of the Home (26.6%; N=29) and the dietician (38.9%; N=37). About 10

EXHIBIT 4.1

## Persons Involved in the Reassessment Process of Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Involved in the Reassessment Process*

| Persons | Usually Involved | | Sometimes Involved | | Never Involved | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | N | % | N | % | N | Not Applicable | Don't Know |
| Head nurse | 96.4 | 53 | 3.6 | 2 | 0.0 | 0 | 66 | 12 |
| Unit/ward supervisor | 95.9 | 47 | 4.1 | 2 | 0.0 | 0 | 67 | 17 |
| Social worker | 78.3 | 36 | 17.4 | 8 | 4.3 | 2 | 71 | 16 |
| Other R.N. staff | 77.9 | 81 | 20.2 | 21 | 1.9 | 2 | 17 | 12 |
| Resident's physician | 73.5 | 75 | 20.6 | 21 | 5.9 | 6 | 20 | 11 |
| Director of nursing | 68.9 | 82 | 27.7 | 33 | 3.4 | 4 | 10 | 4 |
| R.N.A. staff | 65.9 | 58 | 28.4 | 25 | 5.7 | 5 | 34 | 11 |
| H.C.A./orderly | 65.5 | 74 | 26.5 | 30 | 8.0 | 9 | 13 | 7 |
| Medical director | 64.0 | 73 | 31.6 | 36 | 4.4 | 5 | 10 | 9 |
| Adjuvant | 59.0 | 59 | 32.0 | 32 | 9.0 | 9 | 21 | 12 |
| Family members | 50.4 | 58 | 47.8 | 55 | 1.7 | 2 | 10 | 8 |
| Dietician | 38.9 | 37 | 42.1 | 40 | 18.9 | 18 | 26 | 12 |
| Administrator | 26.6 | 29 | 48.6 | 53 | 24.8 | 27 | 12 | 12 |

Homes reported that their recreation coordinator usually takes part in the process and a few Homes also mentioned the housekeeper (N=5) and the resident (N=5).

## 4.2 Care Planning

The following results pertain to individual care plans as well as care conferences.

### 4.2.1 Individual Care Plans

Almost all Homes (95.9%; N=117) indicated that individual care plans were prepared for each resident with moderate or severe dementia. Most of these Homes (64.3%; N=72) review the plans more than once a year, and some (33.0%; N=37) review the plans about once a month. On average, plans are reviewed about four times annually. Most (69.0%; N=78) of the Homes said that the individual care plans for residents with moderate or severe dementia were reviewed about as often as plans for other residents in the Home. In about one third (31.0%; N=35) of the responding Homes, the plans were reviewed more often.

Persons usually involved in individual care planning for residents with moderate or severe dementia are shown in Exhibit 4.2.1. As the Exhibit clearly shows, all Homes with a head nurse (100.0%; N=56) and almost all Homes with unit supervisors (94.2%; N=49) responded that these persons are usually involved in individual care planning. Most Homes also reported the involvement of other R.N. staff members (85.7%; N=90), R.N.A. staff members (83.9%; N=73), HCA/orderlies (83.0%; N=93), social worker (80.0%; N=40) and adjuvants (75.5%; N=74).

Fewer Homes reported the participation of the administrator (15.7%; N=16), the medical director (35.2%; N=38), the resident's physician (35.4%; N=34) and family members (39.4%; N=43). Some Homes (N=11) added that their recreation coordinator and/or the chaplain as well as the housekeeper (N=6) are also usually involved in individual care planning for residents with moderate or severe dementia.

EXHIBIT 4.2.1

## Persons Involved in Individual Care Planning for Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

| Persons | *Per Cent and Number of Homes Who Say Person/Service Usually, Sometimes or Never Involved in Individual Care Planning* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Usually Involved | | Sometimes Involved | | Never Involved | | Number of Missing Observations | |
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Head nurse | 100.0 | 56 | 0.0 | 0 | 0.0 | 0 | 68 | 9 |
| Unit/ward supervisor | 94.2 | 49 | 5.8 | 3 | 0.0 | 0 | 67 | 14 |
| Other R.N. staff | 85.7 | 90 | 14.3 | 15 | 0.0 | 0 | 21 | 7 |
| R.N.A. staff | 83.9 | 73 | 16.1 | 14 | 0.0 | 0 | 39 | 7 |
| H.C.A./orderly | 83.0 | 93 | 17.0 | 19 | 0.0 | 0 | 17 | 4 |
| Social worker | 80.0 | 40 | 16.0 | 8 | 4.0 | 2 | 70 | 13 |
| Adjuvant | 75.5 | 74 | 21.4 | 21 | 3.1 | 3 | 24 | 11 |
| Dietician | 61.2 | 60 | 33.7 | 33 | 6.1 | 6 | 26 | 8 |
| Director of nursing | 58.9 | 66 | 36.6 | 41 | 4.5 | 5 | 15 | 6 |
| Family members | 39.4 | 43 | 57.8 | 63 | 2.8 | 3 | 15 | 9 |
| Resident's physician | 35.4 | 34 | 43.8 | 42 | 20.8 | 20 | 25 | 12 |
| Medical director | 35.2 | 38 | 51.9 | 56 | 13.0 | 14 | 15 | 10 |
| Administrator | 15.7 | 16 | 49.0 | 50 | 35.3 | 36 | 16 | 15 |

### 4.2.2 Care Conferences

Over 90% of the Homes (91.3%; N=105) said that they conduct care planning conferences with staff on the unit or ward to review individual care plans. Persons who usually participate in these conferences, according to most Homes, are the same staff involved in individual care planning and include the head nurse (96.1%; N=49), the H.C.A./orderly (88.8%; N=87), other R.N. staff members (86.8%; N=79), the unit/ward supervisor (85.7%; N=42), the R.N.A. staff members (84.4%; N=65), the social worker (77.1%; N=48), the adjuvant (74.4%; N=67) and the dietician (60.5%; N=52). As is the case for individual care planning sessions, the Homes' administrators, residents' physicians, medical directors and family members are not usually present.

### 4.2.3 Differences in Care Planning for Residents with Moderate or Severe Dementia and Other Residents

Respondents were asked to indicate whether there were any differences in care planning for residents with moderate or severe dementia and planning for other residents, in terms of the aspects listed below. Most Homes said there were no differences, as indicated below (per cent and number of Homes given in brackets):

- *number of professional disciplines involved (85.7%; N=96);*
- *extent of family participation (74.8%; N=83);*
- *content of care plan (64.6%;N=73).*

## 5.0 TECHNOLOGY, PHYSICAL ENVIRONMENT AND CARE PRACTICES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

This section describes the use of technology and the physical environment created for residents with moderate or severe dementia living outside special care units. The discussion includes the different arrangements that Homes make for the location of these residents, the use of restraints and other interventions or preventive measures to deal with problem behaviours.

### 5.1 Location of Residents with Moderate or Severe Dementia

Respondents were provided with five statements that describe possible locations or physical arrangements that Homes may make for residents with moderate or severe dementia, and were asked to circle the statement that most accurately reflects the location of these residents in their Home. Respondents were also asked to indicate the advantages and disadvantages of their arrangement.

Possible arrangements were: caring for residents on a separate or special care unit; special groupings in various areas throughout the Home; planned integration where residents are cared for throughout the Home but where no special space is allocated for them; residents are placed as beds become available (in other words, no special arrangement); and some other type of arrangement or combination of arrangements.

The Homes' responses are given in Exhibit 5.1. While most Homes have only one type of arrangement (77.7%; N=94), almost one quarter (22.3%; N=27) indicated one or more types of physical arrangements for the care of their residents with moderate or severe dementia. The arrangement indicated most frequently is a separate ward or unit such as a special care unit; which may be located on one ward or more than one ward. More than one third (34.7%; N=42) of the Homes said they have this type of arrangement exclusively, and at least another 10 (8.4%) have a separate unit arrangement in combination with another type of location.

Just over 20% (20.6%; N=25) of the Homes use a planned integration approach either alone or in combination with another arrangement. Another arrangement used by about 10% of the Homes

EXHIBIT 5.1

## Physical Location of Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged

| ***One Type of Arrangement:*** | *Number of Homes* | *Per Cent* |
|---|---|---|
| Special care unit | 42 | 34.7 |
| Planned integration | 17 | 14.0 |
| Special groupings | 11 | 9.0 |
| No special arrangement | 11 | 9.0 |
| Other single arrangements | 13 | 10.7 |
| ***More than One Type of Arrangement:*** | | |
| Special care unit and other | 10 | 8.4 |
| Planned integration and other | 8 | 6.6 |
| Special groupings and other | 2 | 1.7 |
| More than two arrangements | 7 | 5.8 |
| **Total** | **121** | **100.0** |

Number of Missing Observations = 12

(10.7%; N=13) is locating residents with moderate or severe dementia in special groupings in various areas throughout the Home. Fewer residents are cared for in each group than is the case in a special or separate care unit.

The variety of arrangements used by the Homes for the care of residents with moderate or severe dementia is reflected in the number of Homes which report numerous other single arrangements (10.7%; N=13), including temporary arrangements until beds become available or proper assessment is made, as well as multiple arrangements (5.8%; N=7) of three or more types.

### 5.1.1 Advantages and Disadvantages of Different Types of Physical Arrangements

Respondents were asked their opinions about the main advantages and disadvantages of the physical arrangement(s) their Home uses for the care of residents with moderate or severe dementia. A variety of responses were given for each arrangement, although there were some patterns in the answers. The most frequently mentioned advantages and disadvantages of each arrangement are listed below. In some cases, the response patterns show that respondents are divided over the merit of the approach used by their Home.

*Special Care Units*

Respondents whose Homes had a separate or special care unit (SCU) arrangement felt some major advantages were:

- *the ability to provide a safe environment for wanderers;*
- *the ability to have a specialized staff team and programs;*
- *less strain on residents without dementia in the Home;*
- *the ability to implement more effective staffing arrangements (ie. in terms of schedules);*
- *residents have more freedom.*

Some common disadvantages of special care units expressed by respondents included:

- *segregation of residents from the more "normal" residents in the rest of the Home;*
- *dislike of some of the environmental approaches such as locked doors;*
- *difficulty in recruiting staff to work on the unit;*
- *the opinion that visitors, including volunteers, are often overwhelmed or intimidated by the residents of the unit.*

*Planned Integration*

Respondents whose Homes favoured planned integration gave the following advantages most often:

- *It was therapeutic for these residents to be around other residents;*
- *Less staff time was used, since other residents help;*
- *Other residents feel needed when they can help.*

The major disadvantages of planned integration according to the Homes that have this arrangement are:

- *It is disruptive to other residents;*
- *It is difficult to monitor or supervise residents;*
- *It is difficult to arrange special care or programs;*
- *Residents are sometimes incompatible.*

*Special Groupings*

Respondents whose Homes have arranged special groupings for the care of residents with moderate or severe dementia gave the following advantages:

- *Staff have shared work load and have more time to monitor residents;*
- *It is safer for wanderers;*
- *Residents without dementia are able to help.*

The major disadvantages of this type of arrangement, according to respondents are:

- *It is disruptive for other residents;*
- *It is harder to supervise wanderers;*
- *It is difficult to provide programs.*

*Other or No Special Arrangements*

Respondents whose Homes had other or no special arrangements were less decisive about their merits. A few respondents (N=7) said that they felt having no special arrangement in their Home was preferable because it was better therapeutically for residents with moderate or severe dementia to be around "normal" residents. There were no other advantages provided by more than one respondent. A substantial number (N=12) of the respondents, however, felt that a major disadvantage of having no planned arrangement for the care of residents with moderate or severe dementia was the disruption this caused for other residents in the Home.

There were no clear trends in the responses regarding advantages and disadvantages of other arrangements.

## 5.2 Physical Environment and Technological Aids

Respondents were asked about environmental modifications and strategies that have been tried in response to the care needs of their more frail residents living outside the special care unit (if the Home has one). Homes were asked to consider several different types of strategies including those intended to increase security and improve visual access, strategies to increase residents' orientation and wayfinding, strategies intended to reduce jostling and accommodate wandering, noise control strategies and other measures intended to reduce sensory overload, and strategies intended to compensate for sensory deficits. The Homes' responses are described below and in Exhibit 5.2.

EXHIBIT 5.2

## Physical Environment and Technological Aids Used in the Care of Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

| *Physical Environment and Technological Aid* | *Per Cent and Number* of Homes That Report the Use of Each Aid* | |
|---|---|---|
| | *Per Cent* | *Number* |
| **Strategies intended to increase security and improve visual access** | | |
| Alarming, coding, or securing door exits | 83.1 | 98 |
| Securing outside areas used by resident | 52.2 | 60 |
| Modifying nurses' stations to improve view of area | 46.1 | 53 |
| Use of wide-angle mirrors on unit | 36.5 | 42 |
| Securing adjacent elevator openings | 10.4 | 11 |
| Video camera surveillance | 8.8 | 10 |
| **Reality orientation materials as to time/place** | | |
| Reality orientation materials | 88.5 | 100 |
| Symbols or signs marking residents' door | 82.9 | 97 |
| Extra large signs or picture signs | 73.0 | 84 |
| Removal of misleading stimuli such as artwork | 21.1 | 23 |
| **Strategies to reduce jostling and accommodate wandering** | | |
| Creation of spaces outdoors for wandering | 43.9 | 50 |
| Creation of spaces indoors for wandering | 33.3 | 37 |
| Increased square footage for lounges | 25.7 | 29 |
| **Noise control strategies to reduce sensory overload** | | |
| Use of carpeting or sound-absorbing finishes | 40.0 | 46 |
| Planned use of background music | 38.6 | 44 |
| Elimination of intercom or public address system | 28.1 | 32 |

*Number of Homes responding to each item ranges from 106 to 120

EXHIBIT 5.2 (cont'd)

## Physical Environment and Technological Aids Used in the Care of Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

| *Physical Environment and Technological Aid* | *Per Cent and Number* of Homes That Report the Use of Each Aid* | |
|---|---|---|
| | *Per Cent* | *Number* |
| **Strategies intended to compensate for sensory deficits** | | |
| Use of contrast to show where differences occur/exit doors | 74.8 | 83 |
| Measures to reduce glare on floors and windows | 61.4 | 70 |
| Increased lighting | 60.2 | 68 |
| Even lighting levels | 59.5 | 66 |
| Use of textured finishes | 52.7 | 59 |
| Elimination of contrast | 41.7 | 48 |
| **Safety/security measures** | | |
| ID bracelets | 55.8 | 67 |
| Doors lock with key or combination | 48.3 | 57 |
| Electronic sensors on doors | 35.6 | 42 |
| Controlled access system or key to elevators | 16.7 | 18 |
| Electronic sensors on elevators | 12.0 | 13 |
| **Assistive aids** | | |
| Special bath aids | 64.9 | 76 |
| Specially designed eating utensils | 52.1 | 61 |
| Emergency response systems | 19.1 | 21 |

*Number of Homes responding to each item ranges from 106 to 120.

### 5.2.1 Security and Visual Access

Respondents were presented with a list of six different strategies that could be used to increase security and improve visual access. As Exhibit 5.2 shows, implementation of these strategies varies greatly. For instance, almost all Homes which responded (83.1%; N=98) said they have implemented alarming, coding or securing of door exits, and about half (52.2%; N=60) have secured their patio and garden areas and modified the nurses' station to improve staff view of surrounding area (46.1%; N=53).

Strategies used less frequently include the use of wide-angle mirrors in the unit (36.5%; N=42); coding, securing, camouflaging of elevators opening on or adjacent to the unit (10.4%; N=11); and video camera surveillance (8.8%; N=10).

### 5.2.2 Orientation and Wayfinding

Four strategies intended to increase residents' orientation and wayfinding were listed in the questionnaire. (See Exhibit 5.2.) All but one have been adopted by most Homes in the study. Almost all respondents report the use of reality orientation boards or other materials orienting residents to time and place. Most (82.9%; N=97) also use symbols or signs marking each resident's door, and extra large signs or picture signs in general (73.0%; N=84). About one fifth (21.1%; N=23) of the Homes in the study said they have removed misleading stimuli such as artwork.

### 5.2.3 Wandering

Most Homes have not implemented any of the listed strategies intended to reduce jostling and accommodate wandering. (See Exhibit 5.2.) Just over 40% (43.9%; N=50) of the respondents reported that their Home has created indoor spaces for wandering. Exactly one third (33.3%; N=37) reported the creation of outdoor spaces for wandering, and about one quarter (25.7%; N=29) have increased their square footage for lounges.

### 5.2.4 Sensory Overloads and Deficits

Respondents were presented with three noise control strategies and other measures intended to reduce sensory overload. (See Exhibit 5.2.) Forty per cent (40.0%; N=46) of Homes reported the use of carpeting or other sound-absorbing finishes, and almost the same number (38.6%; N=44) said they use background music. As well, just over one quarter (28.1%; N=32) have eliminated the intercom or public address system in the units where residents with moderate or severe dementia reside.

Respondents were asked whether their Home had adopted any of six strategies intended to compensate for sensory deficits. (See Exhibit 5.2.) Many Homes in the study have implemented some of these strategies. For example, three quarters (74.8%; N=83) of the respondents reported the use of contrast to show where differences occur (i.e. contrasting colours or other contrasts between floors and walls, doors and door knobs, dishes and table surfaces). About 40% (41.7%; N=48) of the Homes eliminated contrasts where no differences occur, such as the elimination of patterns or lines on the floor.

About 60% of Homes have implemented measures to reduce glare on floors and windows (61.4%; N=70), have increased lighting (60.2%; N=68), and have even lighting levels (59.5%; N=66). About half (52.7%; N=59) of the Homes in the study use textured finishes on the walls, furniture or decorative elements to provide tactile stimulation.

### 5.2.5 Most and Least Recommended Physical Environmental Strategies

Respondents were asked whether the Home used any particularly successful environmental modifications and strategies for residents with moderate or severe dementia that others would like to hear about. There were many different responses given. However, eleven Homes mentioned the **use of contrast** to show where differences occur, nine Homes mentioned the use of **symbols**, and seven mentioned **alarmed doors**.

When asked which strategies were **least successful**, far fewer responses were given. Five Homes, however, would not recommend the use of **carpeting**, three said that the use of colour was not noticed, and two Homes said the use of contrast was not successful. Two Homes also mentioned that circular halls encouraged endless pacing.

### 5.2.6 Major Modifications

Some Homes have incorporated more major modifications or additions. For example, about 30% of the respondents have converted communal bathrooms to private bathrooms (31.5%; N=34) or multiple occupancy rooms to private rooms (31.2%; N=34), or added a special unit or wing to an existing building to create a separate facility for residents with dementia (30.6; N=34). Twelve Homes (10.8%) reported the construction of a separate new Home on the same or adjacent property.

### 5.2.7 Safety and Security Measures

Over half of the Homes in the study have implemented the use of ID bracelets (55.8%; N=67) and almost half (48.3%; N=57) have doors that lock with a key or combination security system. Other reported safety and security measures include electronic sensors on doors (35.6%; N=42), a controlled access system or key to elevators (16.7%; N=18), and electronic sensors on elevators (12.0%; N=13).

### 5.2.8 Technological and Assistive Aids

The majority of Homes reported the use of special bath aids (64.9%; N=76) such as grab bars and shower stools and over half (52.1%; N=61) use specially designed eating utensils. Just under 20% (19.1%; N=21) reported having an emergency response system.

## 5.3 Care Strategies

In order to gain information on the care environment of different Homes, respondents were given a series of statements about the organization of daily activities for residents with moderate or severe dementia, and for each statement, were asked if their Home was "very much like this, somewhat like this or not at all like this". Exhibit 5.3 lists the statements and number and proportion of Homes which indicated that their Home was "very much like this" "somewhat like this" or "not at all like this". The Exhibit demonstrates both consensus and diversity in the responses across Homes.

EXHIBIT 5.3

## Organization of Daily Activities for Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number* of Respondents that say their Home is:*

| Statements About the Care of Residents with Moderate or Severe Dementia | *Very Much Like this* | | *Somewhat Like this* | | *Not at All Like this* | |
|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* |
| We provide meals at regularly scheduled times | 97.5 | 119 | 2.5 | 3 | 0.0 | 0 |
| Residents are encouraged to decorate their rooms with their favourite belongings | 90.2 | 110 | 9.8 | 12 | 0.0 | 0 |
| Provisions are made for residents to have privacy during bathing | 88.5 | 108 | 10.7 | 13 | 0.8 | 1 |
| Provisions are made for residents to obtain snacks when they wish | 66.1 | 80 | 28.1 | 34 | 5.8 | 7 |
| Residents are offered a choice of clothing to wear | 63.9 | 78 | 33.6 | 41 | 2.5 | 3 |
| Meals are served one course at a time | 58.7 | 71 | 27.3 | 33 | 14.0 | 17 |
| Residents are toiletted every two hours | 57.9 | 70 | 36.4 | 44 | 5.8 | 7 |
| Residents must be clean and dressed before meals | 51.6 | 63 | 42.6 | 52 | 5.7 | 7 |
| All residents with moderate or severe dementia eat the same meals | 45.9 | 56 | 32.0 | 39 | 22.1 | 27 |
| Residents with moderate or severe dementia spend more time in group than in individual activities | 40.8 | 49 | 43.3 | 52 | 15.8 | 19 |
| Staff spend a good deal of time interacting with residents on an individual basis | 37.7 | 46 | 56.6 | 69 | 5.7 | 7 |
| Staff spend considerable time organizing group activities for these residents | 37.5 | 45 | 45.8 | 55 | 16.7 | 20 |
| School children are encouraged to pair up with the residents | 28.1 | 34 | 43.0 | 52 | 28.9 | 35 |
| Most of the residents go to bed when they wish | 21.3 | 26 | 63.1 | 77 | 15.6 | 19 |
| Residents go walking outside on a daily basis | 16.4 | 20 | 52.5 | 64 | 31.1 | 38 |
| Residents are toiletted in a group | 4.9 | 6 | 16.4 | 20 | 78.7 | 96 |
| Residents get up in the morning when they wish | 4.9 | 6 | 55.4 | 67 | 39.7 | 48 |
| Residents with moderate or severe dementia are allowed to keep pets | 4.1 | 5 | 16.5 | 20 | 79.3 | 96 |

*Total number of Homes who responded to each statement varied from 120 to 122.

A few elements of the care environment were adhered to by almost all Homes, as indicated by the high proportion of respondents who said their Home was "very much like this". Almost all Homes said that they "provided meals at regularly scheduled times" (97.5%; N=119) and that "residents are encouraged to decorate their rooms with their favourite belongings" (90.2%; N=110). Almost as many indicated "provisions are made for residents to have privacy during bathing" (88.5%; N=122).

Most Homes also said their Home was "not at all like this", in reference to two aspects of the care environment. Most Homes do not allow residents with moderate or severe dementia to keep pets (79.3%; N=96) and residents are not toiletted in groups (78.7%; N=96).

Homes vary in their approach to several aspects of the care environment for residents with moderate or severe dementia, as indicated by statements drawing an even distribution of responses across the three response categories in Exhibit 5.3. For instance, some Homes may feel it is advantageous for residents with moderate or severe dementia to be paired up with school children (28.1% say their Home is very much like this) while others clearly do not (28.9% say their Home is not at all like this). This type of difference in approach among Homes is also found with respect to whether or not most residents can go to bed when they wish (21.3% say their Home is very much like this and 15.6% say their Home is not at all like this), and to a lesser degree whether or not staff spend a great deal of time organizing group activities for residents with moderate or severe dementia (37.5%% vs. 16.7%).

The approach to meals and snacks is another area where there is some variance in approach. While clearly most Homes make provisions for residents to obtain snacks when they wish (indicated by 66.1%; N=80 who say their Home is "very much like this"), a substantial number of Homes say their Home is only "somewhat like this" (28.1%; N=34) or "never like this" (5.8%; N=7). In the same way, just over half (58.7%; N=71) say their Home is "very much like this" when it comes to serving meals one course at a time. Over 40% (41.3%; N=40), however, say their Home is "somewhat or never like this" indicating some flexibility in the approach to meal serving in Homes across the province.

## 5.4 Strengths and Improvements in Care Strategies

Respondents were asked in an open-ended question what they perceived to be the three major strengths of their Home's care strategies for residents with moderate or severe dementia. Almost all respondents (N=115) gave their opinions. These opinions were analyzed in depth and categorized by invited practitioners at a workshop[5] The responses varied but workshop participants grouped most of them into four major categories. These were:

- *family involvement in care planning;*
- *individualized care planning allowing maximum freedom of choice;*
- *caring and educated staff;*
- *multidisciplined approach.*

Respondents were also asked what improvements they would like to see in their own Homes with respect to overall care strategies for residents with moderate or severe dementia. The most frequently given responses by the 108 Homes which had an opinion could be grouped into the following:

- *more education for staff;*
- *more staff, particularly adjuvant;*
- *more activity time in the evening and on weekends;*
- *more variety of activities, including one on one;*
- *improvements in the physical environment.*

## 5.5 Use of Restraints

Virtually all of the Homes in the study which had residents with moderate or severe dementia (N=114) reported that they use some forms of restraints under certain circumstances. Only nine Homes said they never use restraints. In almost one third (31.6%; N=36) of the responding Homes which use restraints, the policy is one of least restraint. Half (49.1%; N=56) of the Homes said they only use restraints under a doctor's orders, and just under this number (41.2%; N=47) use restraints as a form of safety device to prevent residents with moderate or severe dementia from hurting themselves.

Homes were asked whether or not they used a list of common restraints. Exhibit 5.5 shows the proportion of Homes in the study that indicated they used each type of restraint at least once. The Exhibit reveals that the restraint used by most Homes is the geri chair (88.4%; N=99), followed by chemical restraints (86.5%; N=96), the lap belt (74.3%; N=81) and the jacket restraints (41.8%; N=46). About one quarter (27.2%; N=31) of the Homes mentioned additional restraints used including the posey bar, T-tie, alarm door, locked door, bed belt and side rails.

In most cases, restraints are used for residents with moderate or severe dementia as frequently or less than for other residents in the Home. However, in almost 40% of the Homes, chemical restraints (39.6%; N=44) and the geri chair (38.4%; N=43) are used more often for residents with moderate or severe dementia than for other residents in the Home.

Families of residents are usually advised or consulted on each decision to use a restraint on their relative by almost two thirds (63.1%; N=91) of the Homes in the study. In some Homes (9.6%; N=11), families are consulted only upon admittance of the resident. In a few other Homes families are only informed after frequent use of restraints.

## 5.6 Common Interventions for Problem Behaviours

Respondents were given a list of problem behaviours typically displayed by residents with moderate or severe dementia, and asked how each of these behaviours are mediated by staff in the Home. Up to three measures could be listed. The behaviours were wandering, abusive or aggressive behaviour, agitation (pacing, continuously chatting), hoarding or rummaging, and incontinence. The results revealed that different types of interventions are used for different behaviours. The number of residents displaying each of these behaviours in the Homes which responded to the survey was shown earlier in Exhibit 2.3.5.

Of all the types of interventions used for wandering, the ones mentioned by most Homes (as one of three interventions used) are alarms (45.5%; N=56), increasing staff (36.6%; N=45) and diversion tactics (32.4%; N=38). For abusive or aggressive behaviour, Homes usually implement an increase in staff (66.7%; N=82), a chemical restraint (32.5%; N=40) or a diversion tactic (25.2%; N=31). Diversion is the most common intervention used for agitated residents (53.7%; N=66), followed by increase in staff (44.7%; N=55) and the use of a chemical restraint (23.6%; N=29).

EXHIBIT 5.5

## The Use of Restraints by Type for Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number* of Homes Reporting the Use of Each Type of Restraint*

| ***Type of Restraint*** | *Per Cent* | *Number of Homes* |
|---|---|---|
| Geri chair | 88.4 | 99 |
| Chemical restraint | 86.5 | 96 |
| Lap belt | 74.3 | 81 |
| Jacket Restraint | 41.8 | 46 |

*Total number of Homes responding to each restraint ranges from 109 to 112.

The Homes in the study reported different strategies used for the prevention of hoarding or rummaging. Most commonly employed are frequent room checks (51.2%; N=63), followed by locked closets (23.6%; N=29) or diversion tactics (23.6%; N=29). By far the most common preventive measure used by Homes in the study for incontinence are regular toilet routines (91.1%; N=112). Over one third (39.8%; N=49) of the Homes also reported the use of diapers.

## 5.7 Palliative Care

More than half (57.4%; N=70) of the respondents reported having a policy with respect to palliative care for residents with moderate or severe dementia. Over 50 Homes (42.6%), however, did not offer this type of care. For those Homes which did offer palliative care, the majority (61.4%; N=70) said that the care is provided on the resident's unit in his or her own bed. The remaining one third (32.9%; N=23) of the Homes offer palliative care in a sick bay on the unit.

## 6.0 PROGRAMS AND SERVICES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

There were several items in the questionnaire dealing with the specific types of programs and services offered to residents with moderate or severe dementia living outside a special care unit, if the Home had one. Respondents were not only asked how programs and services were planned but also to list three or four of their **most relevant and effective** in-house and outreach programs. Questions asked about each program included: how often it was offered, where it was offered, whether the program was a group or individual program, the percentage of residents with moderate or severe dementia who typically take part, and whether or not residents without dementia also attend.

### 6.1 Planning Programs and Services

Just under half (47.5%; N=58) of all Homes in the study reported that they hold unit or ward meetings to plan programs or services for residents with moderate or severe dementia. Of those that do, most Homes (69.1%; N=38) meet at least once a month, although almost one third (30.9%; N=17) meet less often. Of this latter group, quarterly meetings are the most common (76.4%; N=13).

Exhibit 6.1 shows the type of persons who usually attend the planning meetings. Over 80% of Homes which hold planning meetings and have an adjuvant on staff (82.4%; N=42) say that this person usually attends these meetings. This is followed in proportion by the head nurse (78.8%; N=26), the unit/ward supervisor (75.9%; N=22), other R.N. staff members (72.3%; N=34), and the H.C.A./orderly (70.0%; N=35). Those usually not present include the resident's physician (6.7%; N=3), the administrator (11.8%; N=6) and family members (12.2%; N=6).

### 6.2 Effective In-House Programs

In-house programs for residents with moderate or severe dementia in Ontario's Homes for the Aged considered most effective cover a wide range. Responding Homes reported over thirty different types of programs offered. The most popular programs, however, fall into seven groups. These

EXHIBIT 6.1

## Persons Involved in Planning Programs (Not Resident-Specific) for Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes That Say Person/Service Usually, Sometimes or Never Involved in Planning Programs*

| ***Persons*** | Usually Involved | | Sometimes Involved | | Never Involved | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Adjuvant | 82.4 | 42 | 15.7 | 8 | 2.0 | 1 | 78 | 4 |
| Head nurse | 78.8 | 26 | 15.2 | 5 | 6.1 | 2 | 92 | 8 |
| Unit/ward supervisor | 75.9 | 22 | 3.4 | 1 | 20.7 | 6 | 96 | 8 |
| Other R.N. staff | 72.3 | 34 | 19.1 | 9 | 8.5 | 4 | 80 | 6 |
| H.C.A./orderly | 70.0 | 35 | 14.0 | 7 | 16.0 | 8 | 77 | 6 |
| R.N.A. staff | 61.0 | 25 | 19.5 | 8 | 19.5 | 8 | 86 | 6 |
| Social worker | 60.0 | 18 | 23.3 | 7 | 16.7 | 5 | 94 | 9 |
| Director of nursing | 51.8 | 29 | 35.7 | 20 | 12.5 | 7 | 74 | 3 |
| Dietician | 24.5 | 12 | 40.8 | 20 | 34.7 | 17 | 77 | 7 |
| Medical director | 15.4 | 8 | 28.8 | 15 | 55.8 | 29 | 74 | 7 |
| Family members | 12.2 | 6 | 55.1 | 27 | 32.7 | 16 | 77 | 7 |
| Administrator | 11.8 | 6 | 41.2 | 21 | 47.1 | 24 | 74 | 8 |
| Resident's physician | 6.7 | 3 | 22.2 | 10 | 71.1 | 32 | 78 | 10 |

are: (per cent and number of Homes offering program given in brackets):

- *exercise related (61.8%; N=68);*
- *music related (50.9%; N=56);*
- *crafts and games (40%; N=44);*
- *food related (36.4%; N=40);*
- *activities of daily living (22.7%; N=25);*
- *reality orientation (20.9%; N=23);*
- *social groups (19.1%; N=21).*

Other programs offered but mentioned less often included reminiscence therapy, family support groups, spiritual services and sensory stimulation.

When asked what additional programs they would like to offer, the single response that most Homes in the study gave was more one on one programs.

### 6.2.1 How Often In-House Programs are Held

There is tremendous variety in the number of times programs are offered during the course of a week. Of the total number of programs listed and described (N=371) by the Homes which responded to the question (each Home gave up to four different programs), almost one third (30.9%) are offered once a week. Programs generally held once a week include those that are music or food related as well as reality orientation.

Just over one quarter (27.5%) of the programs (such as craft programs) are held two or three times a week and about one fifth (20.5%) are offered five times per week. Fewer programs are held on a daily basis (including at least one day on the weekend), although about 10% (9.7%) fall into this category. Exercise classes are held daily or almost daily by most Homes that offer them.

### 6.2.2 Location and Type of In-House Programs

Almost as many programs are held directly on the unit (38.1%) as elsewhere in the Home (42.4%). Just under 10% (9.7%) are held in both locations and about the same proportion (10.6%) are held elsewhere outside the Home.

The majority (69.7%) of programs are group programs. Less than 20% (17.4%) are strictly one to one, although just over 10% (12.8%) are both group and individual in focus.

### 6.2.3 Participation in In-House Programs

The participation rate for in-house programs ranges from 1% to 2% of residents with moderate or severe dementia in some Homes to 100% in others. The response given most frequently by the Homes in the study, however, is 50% participation.

For those programs which were group programs, respondents were asked whether only residents with moderate or severe dementia took part or whether other residents were involved as well. The majority (64.9%) of the programs are mixed. Just over one quarter (27.8%) are attended only by residents with moderate or severe dementia.

## 6.3 Effective Outreach Programs

Just over two thirds (68.1%; N=77) of the Homes said they provided some form of outreach programming for people with moderate or severe dementia. Once again, Homes were asked to list three or four of the most effective outreach programs for this population. Almost two dozen different types of programs were mentioned, slightly fewer than the variety of in-house programs available. However, three predominant programs prevailed: meals on wheels, offered by over 60% (61.0%; N=47) of the Homes; day care programs (46.8%; N=36); and respite programs (39.0%; N=30).

Respite and day care programs are two programs that as many as one third of the Homes (34.3%; N=23) would like to offer some day if they had the resources. Most Homes (81.9%; N=86) saw their role in providing outreach to people with moderate or severe dementia as one that would grow in the future.

### 6.3.1 How Often Outreach Programs Are Held

Some outreach programs such as respite care are occasional (although a few Homes report daily respite care); others, such as the day care programs, are regular. In fact, one third (32.6%) of the

178 programs listed in total were provided five days a week. Just under 30% (29.3%) were offered two or three times a week. Meals on wheels falls into this group in many Homes. Almost one quarter (24.1%) of the programs listed, however, are offered only once a week or less. Programs typically offered only once a week are the day-away or drop-in programs.

### 6.3.2 Location and Type of Outreach Programs

As was the case with in-house programs, most (61%) outreach programs are provided on-site in the Homes themselves. The remainder are held elsewhere in the community.

Unlike in-house programs, however, most of the outreach programs provided by the responding Homes in the study are individual programs rather than group oriented. Well over half (56.4%) of the programs mentioned are considered individual.

### 6.3.3 Participation in Outreach Programs

When asked whether or not residents in the Home with moderate or severe dementia take part in any of the outreach programs, most Homes indicated that this was not the case. In fact, the Homes' residents participate in just over one third (37.4%) of the programs mentioned.

Most (57.9%) of the outreach programs, according to the Homes which offer them, are attended by residents with moderate or severe dementia as well as those without dementia. Just 40% (42.1%) are devoted strictly to serving residents with dementia.

### 6.3.4 Funding for Outreach Programs

Very few of the outreach programs offered are funded by the Homes. In fact, one quarter (25.6%) of the programs are funded by the clients themselves. The Ontario Ministry of Community and Social Services provides funding for an additional 12% (11.6%) of programs. Most (56.3%) of the funding, however, is derived from other sources including the United Way.

## 7.0 STAFFING PRACTICES AND RELATED ISSUES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

Respondents were asked several questions with respect to staff and others involved in the care of residents with moderate or severe dementia. Included were items dealing with staffing arrangements and ratios, staffing-related barriers and concerns, as well as staff training, the use of volunteers and other community resources. The results to these questions are described below.

### 7.1 Staffing Arrangements and Ratios

When asked if staffing arrangements on units/wards which care for residents with moderate of severe dementia (outside of the special care unit if the Home has one), are different than those on wards which do not have residents with moderate or severe dementia, almost 60% (59.3%, N=70) of the Homes which responded to the study indicated yes. The main difference, according to these Homes, is the higher ratio of direct care staff to residents on units that have residents with moderate or severe dementia.

Only about half (N=70) of the responding Homes were able to calculate staff/resident ratios separately for units with and without residents who have moderate or severe dementia. In these Homes, the average (calculated mean score) direct care staff/resident ratio on the units that care for residents with moderate or severe dementia is 1:9. The average ratio for most Homes ranges from 1:3 to as high as 1:20.

However, slightly more than three quarters (78.6%; N=55) of the Homes have no more than ten residents to one staff on these wards.

The average ratio on wards without residents with moderate or severe dementia in those Homes which have these wards and could provide a figure (N=48) is 1:15. The range in average staff/resident ratios on these wards is considerably greater - from 1:1 up to 1:40.

Exhibit 7.1 displays a list of staffing-related statements and the proportion of Homes which say that their direct care staff/resident ratio does not allow them to address these aspects of their work. The Exhibit shows that the majority of Homes feel that their staff/resident ratio allows them to carry out

EXHIBIT 7.1

## Work-Related Aspect Pertaining to the Ratio of Direct Care Staff to Residents on Wards that Care for Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

| | *Per Cent and Number* of Homes That Say Rati Does Not Allow for This:* | |
|---|---|---|
| | % | *Number* |
| Monitoring of residents in the evening to ensure their safety | 23.2 | 26 |
| Completion of daily routines at a pace that is comfortable for residents | 35.1 | 40 |
| Sufficient variety in activities offered to residents in the daytime | 35.5 | 39 |
| Appropriate responses to problem behaviour | 39.8 | 43 |
| Ability of residents to perform activities of daily living as independently as possible | 40.2 | 45 |
| Ability of staff to be responsive to residents' needs for individual attention | 47.7 | 53 |
| Provision of programmed activities in the evening | 80.4 | 90 |

*Total number of Homes who responded to each statement ranges from 108 to 114.

most aspects of their work with respect to caring for residents with moderate or severe dementia. There are, nevertheless, substantial numbers of Homes which say that their staff/resident ratio does not allow for them to provide programmed activities in the evening (80.4%; N=90), to be responsive to residents' needs for individual attention (47.7%; N=53), or to allow appropriate responses to problem behaviours (39.8%; N=43).

## 7.2 Staffing-Related Barriers and Concerns

Exhibit 7.2 lists a number of commonly-cited barriers to staff recruitment for Homes for the Aged in Ontario and the proportion of Homes in the study which ranked each barrier as either the most frequently experienced barrier, the second or the third most frequently experienced barrier for each of the major types of staff found in the Home. The staff types include registered nurses (R.N.s), registered nursing assistants (R.N.A.s) and health care assistants (H.C.A.s) or orderlies.

The Exhibit shows that the major barrier to recruitment for each type of staff is "lack of qualified candidates". This barrier is greatest for the recruitment of R.N.s (66.9%; N=81). More than half of the Homes also ranked this barrier as the first, second or third most frequently experienced barrier for H.C.A.s/orderlies (58.7%; N=71) and R.N.A.s (51.2%; N=71).

Another barrier to staff recruitment ranked first, second or third by more than half of the Homes for R.N.s (57.0%; N=69) and H.C.A.s/orderlies (56.2%; N=68) is "lack of interest in working with cognitively impaired". Fewer Homes ranked "poor wages", "low status of job" and "unions" as one of the three top barriers to recruitment, although almost 40% (38.8%; N=47) of the respondents reported low status as a barrier for the recruitment of R.N.s.

In addition to recruitment barriers, respondents were also provided with a list of commonly cited staffing concerns and asked to rank the three most serious concerns with respect to direct care staff in their Home who care for residents with moderate or severe dementia. The staff position that more Homes attributed concerns to than other positions was the health care assistant/orderly. Over half of the Homes in the study said that "absenteeism" (57.9%; N=70), "insufficient training" (52.9%; N=64) and "suitability" (52.1; N=63) were one of the three most serious concerns for these staff members. Other concerns such as turnover, lack of experience, accountability, insufficient

EXHIBIT 7.2

## Commonly Cited Barriers to Recruitment of Staff Who Care for Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Said That Barriers Listed Were the First, Second or Third Most Frequently Experienced by Type of Staff*

| ***Barriers*** | R.N.s | | R.N.A.s | | H.C.A.s/Orderlies | |
|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* |
| Lack of qualified candidates | 66.9 | 81 | 51.2 | 62 | 58.7 | 71 |
| Lack of interest in working with cognitively impaired | 57.0 | 69 | 39.7 | 48 | 56.2 | 68 |
| Low status of job | 38.8 | 47 | 27.3 | 33 | 34.7 | 42 |
| Poor wages | 26.4 | 32 | 26.4 | 32 | 25.6 | 31 |
| Unions | 10.7 | 13 | 12.4 | 15 | 15.7 | 19 |

training or wages, were also considered serious by some Homes but to a much lesser extent (from 19% [wages] to 45% [lack of experience] of Homes with few differences by staff type).

## 7.3 Staff Training

Over 80% (83.5%; N=101) of the Homes reported that the responsibility for staff in-service training is assigned to a staff member. This staff person is usually either an in-service coordinator or in a nursing management position such as the director of nursing. Staff members and others who usually participate in in-service training, according to the Homes in the study, are the unit or ward supervisor (73.2%; N=41) and the head nurse (73.0%; N=46) in those Homes that have this position, as well as other R.N. staff members (71.9%; N=82), H.C.A.s/orderlies (70.8%; N=85), R.N.A. staff members (66.3%; N=63), and the director of nursing (63.1%; N=77). (See Exhibit 7.3.)

Persons who are least likely to participate in in-service training include the resident's physician (0.0; N=0), the medical director (3.4%; N=4), family members (6.3%; N=7), the administrator (11.0%; N=13), the dietician (28.2%; N=29), and housekeeping (37.1%; N=43).

### 7.3.1 Content of Staff Training

Respondents were asked to list and describe three topics presented through in-service training in the last twelve months in the Home that they believed were the most useful and relevant to the care of residents with dementia. Many different topics were listed, but they fall into three basic groups. These are:

- *topics related to the cause and management of Alzheimer's disease;*
- *topics related to dealing with aggression and other difficult behaviours;*
- *topics related to communication with the cognitively impaired individual and validation*

Over three quarters (76.3%; N=90) of the Homes in the study said that they had plans for staff training in the next six to twelve months. Exhibit 7.3.1 illustrates the types of opportunities for

EXHIBIT 7.3

## Persons Participating in In-Service Training for the Care of Residents with Moderate or Severe Dementia Living Outside Special Care Units, by Extent of Involvement in Ontario's Homes for the Aged

*Per Cent and Number of Homes That Say Person/Service Usually, Sometimes or Never Participates in In-Service Training*

| ***Persons*** | Usually Participates | | Sometimes Participates | | Never Participates | | Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* | *Not Applicable* | *Don't Know* |
| Unit/ward supervisor | 73.2 | 41 | 19.6 | 11 | 7.1 | 4 | 68 | 9 |
| Head nurse | 73.0 | 46 | 20.6 | 13 | 6.3 | 4 | 63 | 7 |
| Other R.N. staff | 71.9 | 82 | 24.6 | 28 | 3.5 | 4 | 16 | 3 |
| H.C.A./orderly | 70.8 | 85 | 20.8 | 25 | 8.3 | 10 | 13 | 0 |
| R.N.A. staff | 66.3 | 63 | 23.2 | 22 | 10.5 | 10 | 37 | 1 |
| Director of nursing | 63.1 | 77 | 35.2 | 43 | 1.6 | 2 | 11 | 0 |
| Adjuvant | 51.9 | 55 | 43.4 | 46 | 4.7 | 5 | 21 | 6 |
| Social worker | 48.1 | 26 | 40.7 | 22 | 11.1 | 6 | 70 | 9 |
| Housekeeping | 37.1 | 43 | 51.7 | 60 | 11.2 | 13 | 12 | 5 |
| Dietician | 28.2 | 29 | 62.1 | 64 | 9.7 | 10 | 24 | 6 |
| Administrator | 11.0 | 13 | 55.9 | 66 | 33.1 | 39 | 11 | 4 |
| Family members | 6.3 | 7 | 40.5 | 45 | 53.2 | 59 | 14 | 8 |
| Medical director | 3.4 | 4 | 54.7 | 64 | 41.9 | 49 | 12 | 4 |
| Resident's physician | 0.0 | 0 | 17.4 | 19 | 82.6 | 90 | 18 | 6 |

EXHIBIT 7.3.1

## Future Opportunities for Staff Training on the Care of Residents with Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number* of Homes That Say Opportunity Is Included in Staff Training for the Next Six to Twelve Months*

| ***Opportunity*** | *Per Cent* | *Number* |
|---|---|---|
| Attendance at professional conferences that address aspects of dementia | 73.5 | 64 |
| One-time sessions on dementia conducted by guest speakers invited to the Home | 65.5 | 57 |
| One-time sessions on dementia conducted by qualified staff in the Home | 64.3 | 54 |
| Attendance at courses on dementia sponsored by community-based organizations | 63.0 | 51 |
| On-going sessions on dementia offered in the Home over several weeks | 38.6 | 32 |
| A certificate course organized by the Home to qualify staff to work with residents with dementia in the Home | 12.8 | 10 |

* Total number of Homes responding to each opportunity ranges from 78 to 87.

staff training on the care of residents with dementia that Homes say will be included in their training plan. Opportunities that present themselves the most include attendance at professional conferences (73.5%; N=64), followed by one-time sessions on dementia conducted by guest speakers invited to the Home (65.5%; N=57) or by qualified staff of the Home (64.3%; N=54), and attendance at courses on dementia sponsored by community-based organizations (63.0%; N=51).

Staff training opportunities that are less plentiful are those that occur over the longer term such as on-going sessions on dementia (38.6%; N=32) and certificate courses (12.8%; N=10).

### 7.3.2 Barriers to Training

Respondents were given a list of situations commonly cited as barriers or obstacles to providing in-service training and asked to indicate for each situation whether or not it limited the amount of in-service training available to staff who care for residents with moderate or severe dementia in their Home. The situation cited as a barrier by most Homes is that "staff are too busy on their shift to participate" in training (85.3%; N=99). In fact, almost half (46.6%; N=54) of all Homes in the study ranked this as the main barrier to in-service training.

Almost two thirds (62.9%; N=66) of the responding Homes indicated that there were "no funds to facilitate training courses" and almost one half (48.1%; N=52) said that "the expertise needed to lead sessions is unavailable" in their area. Just over one third (36.5%; N=38) of the Homes reported "few relevant training resources such as booklets or videotapes available".

## 7.4 Volunteers and Family

Respondents were asked several questions concerning the involvement of volunteers including family members in activities for residents with moderate or severe dementia. These questions related to both the extent of involvement and the types of activities carried out.

### 7.4.1 Extent of Volunteer Involvement

Almost all Homes (94.3%; N=115) in the study reported the involvement of volunteers including family members in activities for residents with moderate or severe dementia. When asked what

percentage of their volunteers work with these residents, the average (calculated mean) response was 42.4% of the volunteer force. In about 20% (19.1%; N=18) of Homes, 5% or less of the total number of volunteers are involved with residents who have moderate or severe dementia. In other Homes (N=20), over three quarters of the volunteers assist with activities for residents with moderate or severe dementia.

Respondents were asked to compare the volunteer involvement for residents with moderate or severe dementia and other residents in the Home with respect to a number of aspects. These aspects and the percentage of Homes which said that the involvement was more, the same or less for residents with moderate or severe dementia than for other residents are listed in Exhibit 7.4.1.

The Exhibit shows that for some aspects, volunteer involvement is actually less for residents with moderate or severe dementia than for other residents. About half the Homes, for instance, say that the involvement of volunteers is less with respect to the "amount of time volunteers spend assisting with activities of daily living" (53.3%; N=49) and to the "amount of time volunteers spend with individual residents" (50.0% N=56).

### 7.4.2 Social Visits

In order to get an indication of how often residents with moderate or severe dementia receive individual social visits from family, friends or other volunteers, respondents were asked to estimate the proportions of residents who receive visitors almost daily, once a week, several times a month and so forth. The results were summarized by calculating the mean response (in terms of percentages of residents) given by the Homes in the study for each time frame. These means are presented in Exhibit 7.4.2.

The average percentages presented in Exhibit 7.4.2 suggest that very few residents with moderate or severe dementia in most Homes receive daily visitors (mean=12.9%). About one third (mean=36.3%) on average receive visitors about once a week. Most residents on average, however, in the responding Homes receive visitors less often, and it may be that about one third of residents with moderate or severe dementia receive only casual visits a few times a year or less.

EXHIBIT 7.4.1

## Volunteer Involvement in Different Aspects with Residents With Moderate or Severe Dementia Compared to Other Residents Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number* of Homes That Indicate Tha Involvement Is More, the Same, or Less with than Othe Residents*

| ***Aspect*** | More | | Same | | Less | |
|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* |
| Amount of time volunteers spend with individual residents | 22.3 | 25 | 27.7 | 31 | 50.0 | 56 |
| Amount of time volunteers spend in group programs | 18.9 | 21 | 48.6 | 54 | 32.4 | 36 |
| Amount of time volunteers spend assisting with activities of daily living | 17.4 | 16 | 29.3 | 27 | 53.3 | 49 |
| The proportion of non-family volunteers working with residents | 25.0 | 27 | 33.3 | 36 | 41.7 | 45 |

* Total number of Homes responding to each aspect ranges from 92 to 112.

EXHIBIT 7.4.2

## Proportion of Residents with Moderate or Severe Dementia Living Outside Special Care Units Receiving Social Visits from Family, Friends and Volunteers, by Frequency of Visits in Ontario's Homes for the Aged

| *Frequency of Visits* | *Mean Per Cent* for all Homes* |
|---|---|
| % receiving a visitor almost daily | 12.9 |
| % receiving a visitor about once a week | 36.3 |
| % receiving a visitor a couple of times per month | 23.3 |
| % receiving a visitor about once a month | 21.0 |
| % receiving a visitor several times a year | 16.4 |
| % receiving a visitor about once a year | 12.3 |
| % receiving a visitor less often | 5.6 |

*Per cents are averages and will therefore not sum to 100%.

### 7.4.3 Types of Volunteer Activities

Exhibit 7.4.3 shows the type of activities involving volunteers in the Homes which responded to the study. The activities that involve proportionately the most volunteers are clearly recreation related - either outside the Home, such as accompanying residents on short trips (94.8%; N=109), or inside the Home (93.9%; N=108). As well, almost all Homes (94.7%; N=108) reported involving their volunteers in friendly visiting activities.

Volunteers are least likely, according to the Homes in the study, to be involved in assistance with residents' activities of daily living. Less than half (43.2%; N=48) of the Homes indicated this type of volunteer activity. Assistance with ambulation is another activity that not all Homes involve their volunteers in, although over two thirds (68.4%; N=78) of the responding Home do so.

## 7.5 Paid Companions

The use of paid companions or attendants in providing care to residents with moderate or severe dementia is not commonplace in most Homes. Less than 40% (38.9%; N=47) of Homes in the study said that paid companions had been used in the last twelve months. In those Homes where paid companions or attendants have been employed, it is either the family alone (41.3%; N=19) or the family and the Home's staff (47.8%; N=22) who participate in the hiring and screening of these persons. In almost all cases (89.4%; N=42), the family pays the attendant's wages, although in a few cases, the Homes either assist in the payment or take care of the total amount.

## 7.6 Use of Specialists

Respondents indicated the active involvement of several specialists in the care of residents with moderate or severe dementia. (See Exhibit 7.6.) It should be noted that not all specialists are available in each community across Ontario. In fact, thirty eight (35.2%) Homes indicated that a psychogeriatrician was not available to them. As well, not all Homes reported having access to occupational therapists (N=18) or speech therapists (N=17).

EXHIBIT 7.4.3

## Types of Activities Involving Volunteers for Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

| *Activity* | *Per Cent and Number* of Homes Indicating that Volunteers Are Involved* | |
|---|---|---|
| | *Per Cent* | *Number* |
| Assistance with recreation programming outside the Home | 94.8 | 109 |
| Friendly visiting | 94.7 | 108 |
| Assistance with recreation programming in the Home | 93.9 | 108 |
| Assistance with residents' ambulation | 68.4 | 78 |
| Assistance with residents' activities of daily living | 43.2 | 48 |

*Total number of valid responses for each activity ranges from 111 to 115.

EXHIBIT 7.6

## Availability and Involvement of Specialists in the Care of Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number of Homes Who Report Specialists Are Available in Their Community and Who Are Using Specialists*

| | Available in Community | | Use Specialists | | Number Not Applicable/ Don't Know |
|---|---|---|---|---|---|
| | % | *N* | % | *N* | |
| Physiotherapists | 94.7 | 107 | 75.7 | 81 | 20 |
| Podiatrist | 88.8 | 100 | 72.0 | 72 | 20 |
| Nutritionist | 88.6 | 101 | 70.3 | 71 | 19 |
| Social Worker | 82.6 | 90 | 50.0 | 45 | 24 |
| Occupational Therapist | 83.9 | 94 | 46.8 | 44 | 21 |
| Psychogeritrician | 67.8 | 80 | 45.0 | 36 | 25 |
| Speech Therapist | 84.7 | 94 | 23.4 | 22 | 22 |
| Chiropractor | 93.5 | 100 | 12.0 | 12 | 26 |

The most actively called upon specialists, reported by over 70% of the Homes which had access to these specialists, are physiotherapists (75.5%; N=81), podiatrists (72.0%; N=72) and nutritionists (70.3%; N=71). Close to half of the Homes indicated (where available) the use of psychogeriatricians (45.0%; N=36), occupational therapists (46.8%; N=44) and social workers (50.0%; N=45). Relatively fewer Homes involved chiropractors (12.0%; N=12) or speech therapists (23.4%; N=22).

## 7.7 Use of Community Services

Exhibit 7.7 presents a list of community services and the proportion of Homes reporting that these services provide care to residents with moderate or severe dementia. The Exhibit shows that in addition to family physicians and local hospitals, which almost all Homes are involved with, dental clinics (67.0%; N=73) and foot care clinics (60.5%; N=69) provide care to residents with moderate or severe dementia in a majority of Homes in the study. To a lesser degree, vision clinics (57.5%; N=61) and mental health services (54.1%; N=60) also provide services. The least used community services, according to the Homes in the study, are public health nurses (7.9%; N=9), community resources or health centres (17.3%; N=17), home support agencies (17.9%; N=20), adult day programs (22.1%; N=23) and private nursing services (25.7%; N=27).

EXHIBIT 7.7

## The Use of Community Services for the Care of Residents with Moderate or Severe Dementia Living Outside Special Care Units in Ontario's Homes for the Aged

*Per Cent and Number of Homes That Say Service Is Available and Provides Care to Residents with Moderate or Severe Dementia*

| ***Community Service*** | *Per Cent* | *Number* |
|---|---|---|
| Family physicians | 83.5 | 101 |
| Local hospitals | 80.0 | 96 |
| Dental clinics | 67.0 | 73 |
| Foot care clinics | 60.5 | 69 |
| Vision clinics | 57.5 | 61 |
| Mental health services | 54.1 | 60 |
| Volunteer service bureau | 41.0 | 41 |
| Alzheimer's Society | 40.7 | 44 |
| Seniors' council/organization | 29.6 | 32 |
| Private nursing services | 25.7 | 27 |
| Family counselling | 22.6 | 24 |
| Adult day programs | 22.1 | 23 |
| Home support agencies | 17.9 | 20 |
| Community resources/health centre | 17.3 | 17 |
| Public health nurses | 7.9 | 9 |

## 8.0 COSTS OF CARING FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING OUTSIDE SPECIAL CARE UNITS

Respondents were asked several questions about the Home's costs - both in overall terms as well as the costs incurred for the care of residents with moderate or severe dementia (outside the special care unit if the Home has one). The results to these questions are described here.

### 8.1 Comparing Costs for Residents With and Without Dementia

Exhibit 8.1 displays a list of cost items and indicates whether less, or the same, or more is spent on these items for the care of residents with moderate or severe dementia, compared with the care of other residents. The Exhibit clearly shows that there are no items for which less is spent for the care of residents with moderate or severe dementia than for other residents. In most cases, in fact, the Homes report that the cost items are the same for both types of residents, although more is spent on a number of items in the care of residents with moderate or severe dementia, according to the reporting Homes.

Over three quarters (77.2%; N=88) of the Homes which gave a response said that more is spent on personal care staff time in the care of residents with moderate or severe dementia compared with the care of other residents. Other items for which more is spent are incontinence products (71.4%; N=80), technology/security systems (64.0%; N=64) and repair and maintenance (59.1%; N=65).

### 8.2 Main Cost Items

When asked to rank the same cost items appearing in Exhibit 8.1 in terms of their impact on per-resident cost for the care of residents with moderate or severe dementia, most respondents ranked incontinence products as having the first, second or third greatest impact on costs (63.4%; N=71). (See Exhibit 8.2.) In fact, this was the only cost item that the majority of Homes ranked in the top three. Almost 40% (38.1%; N=43) of respondents ranked training and development as having an important impact on costs, and just over one quarter identified personal care staff time (27.2%; N=31) and assessment (27.7%; N=31) as high impact cost items.

EXHIBIT 8.1

## Cost Comparisons by Cost Item for Residents with Moderate or Severe Dementia Living Outside Special Care Units and Other Residents in Ontario's Homes for the Aged

*Per Cent and Number of Homes That Report Cost Item Is Less, the Same or More in the Care of Residents with Moderate or Severe Dementia and Other Residents*

| | Less | | Same | | More | | Number of Missing Observations | |
|---|---|---|---|---|---|---|---|---|
| ***Cost Item*** | *%* | *N* | *%* | *N* | *%* | *N* | *Don't Know* | *Not Applicable* |
| Personal care staff time | 0.8 | 1 | 21.9 | 25 | 77.2 | 88 | 5 | 14 |
| Training/ development | 1.8 | 2 | 54.9 | 62 | 43.4 | 49 | 6 | 14 |
| Assessment | 0.0 | 0 | 51.8 | 58 | 48.2 | 54 | 7 | 14 |
| Incontinence products | 3.6 | 4 | 25.0 | 28 | 71.4 | 80 | 7 | 14 |
| Other supplies | 1.9 | 2 | 60.6 | 63 | 37.5 | 39 | 15 | 14 |
| Food | 2.7 | 3 | 87.4 | 97 | 9.9 | 11 | 8 | 14 |
| Out-of-pocket expenses | 15.1 | 14 | 72.0 | 67 | 12.9 | 12 | 26 | 14 |
| Repair/ maintenance | 1.9 | 2 | 68.6 | 72 | 29.5 | 31 | 14 | 14 |
| Housekeeping | 1.0 | 1 | 40.0 | 44 | 59.1 | 65 | 9 | 14 |
| Technology/ security systems | 3.0 | 3 | 33.0 | 33 | 64.0 | 64 | 19 | 14 |
| Design related items | 1.2 | 1 | 49.4 | 42 | 49.4 | 42 | 34 | 14 |
| Construction costs | 2.6 | 2 | 60.5 | 46 | 36.8 | 28 | 43 | 14 |
| Special program costs | 1.1 | 1 | 57.6 | 53 | 41.3 | 38 | 27 | 14 |

EXHIBIT 8.2

## Cost Items Ranked as the Top Three Contributors to the Overall Cost of Caring for Residents with Moderate or Severe Dementia Living Outside Special Care Units and Other Residents in Ontario's Homes for the Aged

*Per Cent and Number* of Homes That Ranked Cost Item as First, Second or Third Highest Contributor to overall Cost of Caring for Residents with Moderate or Severe Dementia*

| ***Cost Item*** | *Per Cent* | *Number* |
|---|---|---|
| Incontinence products | 63.4 | 71 |
| Training/development | 38.1 | 43 |
| Assessment | 27.7 | 31 |
| Personal care staff time | 27.2 | 31 |
| Housekeeping | 21.8 | 24 |
| Other Supplies | 15.4 | 16 |
| Food | 14.4 | 16 |
| Construction costs | 13.2 | 10 |
| Technology/security systems | 12.0 | 12 |
| Repair/maintenance | 10.5 | 11 |
| Special program costs | 9.8 | 9 |
| Design related items | 7.1 | 6 |
| Out-of-pocket expenses | 3.2 | 3 |

*Number of Homes who responded to each item ranges from 76 to 114

## 9.0 THE ROLE OF SPECIAL CARE UNITS IN THE CARE OF RESIDENTS WITH MODERATE OR SEVERE DEMENTIA

The final section of the survey, focusing on care practices for residents with moderate or severe dementia living outside special care units, pertained to the perceived role of special care or separate units. Respondents were asked their opinions on the major purposes and goals of special care units, whether they felt the care on special care units was more successful, less successful or no different to the care residents with moderate or severe dementia receive on other units in Homes, and their attitudes with respect to some perceived advantages and disadvantages of special care units.

It was shown earlier in Exhibit 5.1 that as many as 80 Homes may have implemented a form of segregated care for residents with moderate or severe dementia. This includes what is traditionally called the special care unit, but can also include special groupings and multiple arrangements of care where at least one arrangement is segregated. It is estimated that as many as 59 Homes in the study do not currently have a special care unit, although 24 are in the process of developing one. When those Homes with no current plans for a special or separate care unit were asked why they had decided against developing such a unit, most gave either financial or physical structural reasons for not doing so. Some said the need was just not there in their Home or community at the present time.

### 9.1 Major Purposes and Goals of Special Care Units

Almost all responding Homes (N=110) with residents who have moderate or severe dementia, had an opinion about the major purposes and goals of special care units in Ontario, regardless of whether their Home had one. These open-ended responses were easily categorized into several different key points during the workshop (cited in Section 5.4). Most responses related to the **needs of individual residents with moderate or severe dementia** and how these needs could be better fulfilled in a segregated environment. Others, although also responding to individual needs, were more consistent with the **needs of the staff and residents with no cognitive impairment:**

*Meeting Needs of Residents with Moderate or Severe Dementia*

- *providing a safe and secure environment, particularly for wandering;*
- *providing a therapeutic physical and social environment that maximizes residents' abilities to function independently;*
- *improving quality of life by introducing smaller, more familiar and comfortable setting that allows freedom of movement and fosters a sense of worth and dignity;*
- *having trained staff who can provide specialized programs and more individual attention.*

*Meeting Needs of Staff and Cognitively Intact Residents*

- *to provide care to residents who are at similar level of functioning;*
- *to reduce the use of physical and chemical restraints through increased staff involvement;*
- *to respond to problem behaviours that would otherwise be disruptive in non-special care environments;*
- *to maximize resources;*
- *to reduce tension between oriented and confused residents.*

## 9.2 Perceived Success of Special Care Units

Exhibit 9.2 reflects how respondents felt about the success of a number of key issues related to the care of residents on a special or separate care unit compared to other units. The Exhibit shows that on most issues respondents feel special care units are more successful, particularly in areas such as ensuring residents' safety (75.4%; N=89) and responding to problem behaviours (68.6%; N=81).

EXHIBIT 9.2

## Perceived Success of Special Care Units in the Care of Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged

*Per Cent and Number of Homes That Say Special Care Units Are More Successful, Less Successful, No Different or Have No Opinion*

| Care Practice | More Successful | | Less Successful | | No Different | | No Opinion | |
|---|---|---|---|---|---|---|---|---|
| | % | N | % | N | % | N | % | N |
| Completing daily routines with residents at a pace that is comfortable for them | 59.3 | 70 | 0.0 | 0 | 20.3 | 24 | 20.3 | 24 |
| Ensuring residents' safety | 75.4 | 89 | 0.9 | 1 | 5.1 | 6 | 18.8 | 22 |
| Allowing residents to perform activities as independently as possible | 55.9 | 66 | 4.2 | 5 | 19.5 | 23 | 20.3 | 24 |
| Providing appropriate programming | 66.9 | 79 | 7.6 | 9 | 6.8 | 8 | 18.6 | 22 |
| Responding to problem behaviour | 68.6 | 81 | 3.4 | 4 | 7.6 | 9 | 20.3 | 24 |
| Effectiveness of incontinence management | 36.2 | 42 | 3.4 | 4 | 39.7 | 46 | 20.7 | 24 |

*Respondents who felt question did not apply to them ranged from 15 to17.

Two thirds of the responding Homes believe that special care units are more successful in providing appropriate programming (66.9%; N=79). Almost 60% think that special care units are more successful at completing daily routines with residents at a pace that is comfortable for them (59.3%; N=70), although 24 of these respondents (20.3%) believe that there is no difference in this matter between special care units and other units.

A substantial number of respondents (19.5%; N=23) believe there is no difference between special care units and other units when it comes to allowing residents to perform activities as independently as possible, although over half (55.9%; N=66) of the respondents think special care units are more successful. One area of care where most respondents believe either that there is no difference (39.7%; N=46) or that special care units are less successful (3.4%; N=4) is in their effectiveness of incontinence management.

Exhibit 9.2 also reveals the large number of Homes in the study indicating they had no opinion on the effectiveness of special care units compared to regular wards. Between 22 and 24 respondents consistently gave no response. There were also 14 to 15 Homes which felt the question did not apply to their situation. Most of these Homes had no residents with moderate or severe dementia and no special care unit.

## 9.3 Advantages and Disadvantages of Integrated and Segregated Care Arrangements

Respondents were asked to rate (agree-disagree scale) a series of statements about the perceived advantages and disadvantages of integrated care and segregated care (such as special care units) for residents with moderate or severe dementia. The results are given in Exhibit 9.3. The number and per cent of respondents who strongly agree (score=1), moderately agree (score=2), neither agree or disagree (score=3), moderately disagree (score=4) or strongly disagree (score=5) are given for each statement, along with the mean response. The mean response summarizes general agreement (mean score closer to 1), disagreement (mean score closer to 5) or indifference (mean score around 3) for each statement.

Exhibit 9.3 shows that most Homes in the study agree that "cognitively intact residents are often upset by the behaviour of fellow residents with dementia and therefore prefer segregated care". In fact, over 70% (70.1%; N=82) of the respondents said they strongly agreed with this statement,

EXHIBIT 9.3

## Perceived Advantages and Disadvantages of Integrated and Segregated Care for Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged

*SA=Strongly Agree, MA=Moderately Agree, N=Neither Agree or Disagree, MD=Moderately Disagree, SD=Strongly Disagree, X=Average (calculated mean) Score (where SA=1, MA=2, N=3, MD=4, D=5)*

| | SA | | MA | | N | | MD | | SD | | $\bar{X}$ |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | % | *N* | % | *N* | % | *N* | % | *N* | % | *N* | |
| Cognitively intact residents benefit from contact with fellow residents with dementia in an integrated setting. | 5.2 | 6 | 3.5 | 4 | 19.1 | 22 | 29.6 | 34 | 42.6 | 49 | 4.0 |
| Families find segregated settings depressing. | 27.6 | 32 | 31.9 | 37 | 23.3 | 27 | 11.2 | 13 | 6.0 | 7 | 2.4 |
| Residents with dementia are sensitive to rejection from cognitively intact residents and find greater acceptance in segregated settings. | 41.4 | 48 | 30.2 | 35 | 17.2 | 20 | 4.3 | 5 | 6.9 | 8 | 2.1 |
| Special care units are inappropriate for rural areas and small urban centres, since the population is too small to support them. | 1.8 | 2 | 8.9 | 10 | 21.4 | 24 | 18.8 | 21 | 49.1 | 55 | 4.0 |
| Diagnosis of dementia is difiicult and segregation of residents believed to have dementia increases the chances that misdiagnosis will be undetected. | 9.5 | 11 | 21.6 | 25 | 22.4 | 26 | 27.6 | 32 | 19.0 | 22 | 3.3 |
| All residents have much the same care needs that can best be met in an integrated setting focusing on quality care. | 6.0 | 7 | 14.5 | 17 | 12.0 | 14 | 27.4 | 32 | 40.2 | 47 | 3.8 |
| Residents with dementia benefit from contact with residents without dementia who provide a model for behaviour and increased social stimulation. | 7.7 | 9 | 29.1 | 34 | 26.5 | 31 | 18.8 | 22 | 17.9 | 21 | 3.1 |
| The needs of residents with dementia are different from those of other residents and are best met in a special separate unit. | 45.7 | 53 | 25.9 | 30 | 17.2 | 20 | 8.6 | 10 | 2.6 | 3 | 2.0 |
| Turnover among staff who care only for residents with dementia is no different than it is among staff who care for residents without dementia. | 15.0 | 17 | 21.2 | 24 | 27.4 | 31 | 23.0 | 26 | 13.3 | 15 | 3.0 |
| Cognitively intact residents are often upset by the behaviour of fellow residents with dementia and therefore prefer segregated care. | 70.1 | 82 | 21.4 | 25 | 6.0 | 7 | 0.9 | 1 | 1.7 | 2 | 1.4 |
| Segregated care increases the potential for inadequate and inappropriate care for residents with dementia because they cannot speak for themselves. | 5.1 | 6 | 13.7 | 16 | 10.3 | 12 | 19.7 | 23 | 51.3 | 60 | 4.0 |
| A therapeutically- designed environment can best be created in separate units for residents with dementia. | 50.9 | 59 | 29.3 | 34 | 11.2 | 13 | 6.9 | 8 | 1.7 | 2 | 1.8 |
| Special care units are appropriate outside urban areas since families will travel considerable distances to maintain a relative in a special care unit. | 14.0 | 16 | 17.5 | 20 | 28.1 | 32 | 15.8 | 18 | 24.6 | 28 | 3.2 |

reflected in the mean score (1.4). As well, 80% (80.2%, N=93) of the respondents either strongly or moderately agree that a "therapeutically designed environment can best be created in separate units for residents with dementia".

There was strong disagreement among respondents that "cognitively intact residents benefit from contact with fellow residents with dementia in an integrated setting" (mean score=4.0), as well as that "special care units are inappropriate for rural areas and small urban centre since the population is too small to support them" (mean score=4.0). At the same time, almost three quarters (71.0%; N=83) of the Homes which responded moderately or strongly disagree "that segregated care increases the potential for inadequate and inappropriate care for residents with dementia because they cannot speak for themselves".

There were several statements that respondents are quite divided on in their attitudes with respect to advantages and disadvantages of integrated and segregated care, reflected in the fairly even distribution of percentages across the response categories shown in Exhibit 9.3. There is little consensus, for example, over whether "turnover among staff who care only for residents with dementia is no different than it is among staff who care for residents without dementia", or whether "residents with dementia benefit from contact with residents without dementia who provide a model for behaviour and increased social stimulation".

## 10.0 MEETING FUTURE NEEDS

The final question in the survey of care practices for residents with moderate or severe dementia living outside special care units asked respondents what they believed their Home could do to help in the future, given the changing needs and placement pattern of the elderly in Ontario. Almost three quarters (71.4%; N=95) of the total number of responding Homes gave a response. Their responses could be categorized into three groups of answers. First, many respondents spoke of **renovating and upgrading their facilities,** including the development of a special care unit, more private resident rooms and washrooms, and the introduction of more lounge areas. Second, substantial numbers of Homes saw their future as entailing **more outreach programming** such as respite care, day care, providing an emergency response service to seniors living near by, among others. And thirdly, some respondents mentioned a commitment to **more education and specialized training** for staff who work with residents who have dementia. A few Homes forecasted an increase of applicants with Alzheimer's disease and other forms of cognitive impairment, and indicated that Homes for the Aged must be prepared to offer the specialized services needed for this type of resident, at the same time responding to needs of residents with dementia living elsewhere in the community through more outreach programming.

# APPENDIX A

# LIST OF HOMES SURVEYED

* Homes returned a general care questionnaire and a special care unit questionnaire.

ALBRIGHT MANOR *
R.R. #2
BEAMSVILLE, ONTARIO
L0R 1B0

ALGOMA MANOR *
OWEN STREET
THESSALON, ONTARIO
P0R 1L0

ANSON HOUSE
136 ANSON STREET
PETERBOROUGH, ONTARIO
K9H 5R1

AU CHATEAU *
100 MICHAUD AVE.
STURGEON FALLS, ONTARIO
P0H 2G0

BAYCREST CENTRE FOR GERIATRIC CARE
BAYCREST TERRACE
3560 BATHURST ST.
NORTH YORK, ONTARIO
M6A 2E1

BAYCREST CENTRE FOR GERIATRIC CARE
JEWISH HOME FOR THE AGED
3560 BATHURST ST.
NORTH YORK, ONTARIO
M6A 2E1

BEATTIE HAVEN
R.R. #1
WARDSVILLE, ONTARIO
N0L 2N0

BELMONT HOUSE
55 BELMONT STREET
TORONTO, ONTARIO
M5R 1R1

BELVEDERE HEIGHTS *
21 BELVEDERE AVENUE
PARRY SOUND, ONTARIO
P2A 2A2

BENDALE ACRES
2920 LAWRENCE AVENUE EAST
SCARBOROUGH, ONTARIO
M1P 2T8

BETHANY LODGE
23 SECOND STREET
UNIONVILLE, ONTARIO
L3R 2C2

BIRCHWOOD TERRACE
TERRACE BAY, ONTARIO
P0T 2W0

BLUE WATER REST HOME
ZURICH, ONTARIO
N0M 2T0

BOB RUMBALL CENTRE
2395 BAYVIEW AVENUE
NORTH YORK, ONTARIO
M2L 1A2

BONNECHERE MANOR *
782 RAGLAN STREET
RENFREW, ONTARIO
K7V 4A5

BRONSON HOME
81 BRONSON AVENUE
OTTAWA, ONTARIO
K1R 6G7

BRUCELEA HAVEN
41 McGIVERN STREET WEST
WALKERTON, ONTARIO
N0G 2V0

CAMBRIAN HALL (CNIB)
303 YORK STREET
SUDBURY, ONTARIO
P3E 2A5

CANA PLACE
ST. PAUL'S L'AMOREAUX CENTRE
3333 FINCH AVENUE EAST
SCARBOROUGH, ONTARIO
M1W 2R9

CAREFREE LODGE
306 FINCH AVENUE EAST
WILLOWDALE, ONTARIO
M2N 4S5

CARLETON LODGE *
R.R. #2
NEPEAN, ONTARIO
K2C 3H1

CASSELLHOLME *
400 OLIVE STREET
NORTH BAY, ONTARIO
P1B 6J4

CEDAR GROVE LODGE
101 PINE STREET
CHAPLEAU, ONTARIO
P0M 1K0

CENTRE D'ACCUEIL ROGER SEGUIN *
CLARENCE CREEK, ONTARIO
K0A 1N0

CLARKEWOOD (CNIB)
1929 BAYVIEW AVENUE
TORONTO, ONTARIO
M4G 3E8

CUMMER LODGE
205 CUMMER AVENUE
WILLOWDALE, ONTARIO
M2M 2E8

CARMEL HEIGHTS
CARMELITE SISTERS OF CANADA
1720 SHERWOOD FOREST CIRCLE
MISSISSAUGA, ONTARIO
L5K 1R1

CASTLEVIEW-WYCHWOOD TOWERS *
351 CHRISTIE STREET
TORONTO, ONTARIO
M6G 3C3

CENTRE D'ACCUEIL CHAMPLAIN *
275 PERRIER STREET
VANIER, ONTARIO
K1L 5C6

CHESTER VILLAGE
717 BROADVIEW AVENUE
TORONTO, ONTARIO
M4K 2P5

COPERNICUS LODGE
66 RONCESVALLES AVENUE
TORONTO, ONTARIO
M6R 3A7

DAWSON COURT *
523 NORTH ALGOMA STREET
THUNDER BAY, ONTARIO
P7A 5C2

DEARNESS HOME FOR SENIOR CITIZENS *
710 SOUTHDALE ROAD EAST
LONDON, ONTARIO
N6E 1R8

DORCHESTER MANOR
6350 DORCHESTER ROAD
NIAGARA FALLS, ONTARIO
L2G 5T5

DUFFERIN OAKS *
SHELBURNE, ONTARIO
L0N 1S0

EASTHOLME
200 BIG BEND AVENUE
POWASSAN, ONTARIO
P0H 1Z0

EDGEWOOD HALL (CNIB)
1686 MAIN STREET WEST
HAMILTON, ONTARIO
L8S 1G4

ELGIN MANOR *
R.R. #1
ST. THOMAS, ONTARIO
N5P 3S5

ELLIOTT HOME (THE)
170 METCALFE STREET
GUELPH, ONTARIO
N1E 4Y3

A.R. COUDIE EVENTIDE HOME
SALVATION ARMY
369 FREDERICK STREET
KITCHENER, ONTARIO
N2H 2P1

THE HON. RAY AND HELEN LAWSON
SALVATION ARMY
860 GREAT NORTHERN ROAD
SAULT STE. MARIE
P6A 5K7

F.J. DAVEY HOME *
5050 JEPSON STREET
NIAGARA FALLS, ONTARIO
L2E 1K5

FAIRHAVEN HOME
131 LANGTON STREET
PETERBOROUGH, ONTARIO
K9H 6K3

FAIRMOUNT HOME *
R.R. #1
GLENBURNIE, ONTARIO
K0H 1S0

FAIRVIEW LODGE
632 DUNDAS STREET WEST
WHITBY, ONTARIO
L1N 5S3

FAIRVIEW MANOR
95 SPRINGS STREET
ALMONTE, ONTARIO
K0A 1A0

FAIRVIEW MENNONITE HOME
799 CONCESSION ROAD
CAMBRIDGE, ONTARIO
N3H 4L1

FOYER RICHELIEU RESIDENCE
655 TORGUAY STREET
WELLAND, ONTARIO
L3B 5W5

FRED VICTOR MISSION
139 JARVIS STREET
TORONTO, ONTARIO
M5C 2H6

FUDGER HOUSE *
439 SHERBOURNE STREET
TORONTO, ONTARIO
M4X 1K6

FULFORD HOME
280 KING STREET EAST
BROCKVILLE, ONTARIO
K6V 1E2

GATEWAY HAVEN *
671 FRANK STREET
WIARTON, ONTARIO
N0H 2T0

GEORGIAN MANOR *
7 HARRIETT STREET
PENETANGUISHENE, ONTARIO
L0K 1P0

GILMORE LODGE *
50 GILMORE ROAD
FORT ERIE, ONTARIO
L2A 2M1

GLEBE CENTRE
950 BANK STREET
OTTAWA, ONTARIO
K1S 5G6

GLEN-STOR-DUN LODGE *
1900 MONTREAL ROAD
CORNWALL, ONTARIO
K6H 5T1

GOLDEN MANOR *
481 MELROSE BOULEVARD
TIMMINS, ONTARIO
P4N 5H3

GOLDEN PLOUGH LODGE *
R.R. #4
COBOURG, ONTARIO
K9A 4J7

GOOD SHEPHERD CENTRE
135 MARY STREET
HAMILTON, ONTARIO
L8N 3R1

GRANDVIEW LODGE *
657 LOCK STREET WEST
DUNNVILLE, ONTARIO
N1A 1V9

GRANDVIEW LODGE *
200 LILLIE STREET
THUNDER BAY, ONTARIO
P7C 4Y7

GREENACRES
194 EAGLE STREET
NEWMARKET, ONTARIO
L3Y 1J6

GREY OWEN LODGE
206 TORONTO STREET
MARKDALE, ONTARIO
N0C 1H0

GROVE PARK
234 COOK STREET
BARRIE, ONTARIO
L4M 4T7

HALTON CENTENNIAL MANOR *
185 ONTARIO STREET SOUTH
MILTON, ONTARIO
L9T 2M4

HASTINGS CENTENNIAL MANOR
BOX 758 - OFF MAPLE STREET
BANCROFT, ONTARIO
K0L 1C0

HASTINGS MANOR
476 DUNDAS STREET WEST
BELLEVILLE, ONTARIO
K8N 2B2

HEIDEHOF *
600 LAKE STREET
ST. CATHARINES, ONTARIO
L2N 4J4

HILLCREST LODGE
86 CEDAR STREET
ORILLIA, ONTARIO
L3V 2V5

HILLEL LODGE
125 WURTEMBURG STREET
OTTAWA, ONTARIO
K1N 8L9

HILLSDALE MANOR
600 OSHAWA BOULEVARD NORTH
OSHAWA, ONTARIO
L1G 5T9

HURON LODGE
1475 HURON CHURCH ROAD
WINDSOR, ONTARIO
N9C 2K9

HURONVIEW *
CLINTON, ONTARIO
N0M 1L0

HYLAND CREST SENIOR CITIZEN'S HOME
MINDEN, ONTARIO
K0M 2K0

I.O.O.F. HOME
10 BROOKS STREET
BARRIE, ONTARIO
L4N 5L3

IDLEWYLD MANOR
449 SANATORIUM ROAD
HAMILTON, ONTARIO
L9C 2A7

INA GRAFTON-GAGE HOME (NIAGARA)
413 LINWELL ROAD
ST. CATHARINES, ONTARIO
L2M 2P3

INA GRAFTON-GAGE HOME (TORONTO) *
2 O'CONNOR DRIVE
TORONTO, ONTARIO
M4K 2K1

ISABEL & ARTHUR MEIGHEN LODGE
SALVATION ARMY
100 DAVISVILLE AVENUE
TORONTO, ONTARIO
M4S 1G2

ISLAND LODGE *
1 PORTER'S ISLAND
OTTAWA, ONTARIO
K1N 5M2

IVAN FRANKO HOME
UKRAINIAN HOME FOR THE AGED
767 ROYAL YORK ROAD
ETOBICOKE, ONTARIO
M8Y 2T3

IVAN FRANKO HOME
UKRAINIAN HOME FOR THE AGED
3058 WINSTON CHURCHILL BLVD.
MISSISSAUGA, ONTARIO
L5L 3J1

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET
BRANTFORD, ONTARIO
N3T 1T5

KIPLING ACRES *
2233 KIPLING AVENUE
REXDALE, ONTARIO
M9W 4L3

KNOLLCREST LODGE
50 WILLIAM STREET
MILVERTON, ONTARIO
N0K 1M0

KRISTUS DARZS
11290 PINE VALLEY DRIVE
WOODBRIDGE, ONTARIO
L4L 1A6

LAKEVIEW MANOR *
133 MAIN STREET WEST
BEAVERTON, ONTARIO
L0K 1A0

LAMBTON TWILIGHT HAVEN *
R.R. #4
PETROLIA, ONTARIO
N0N 1R0

LANARK LODGE
R.R. #4
PERTH, ONTARIO
K7H 3C6

LEAMINGTON MENNONITE HOME
22 GARRISON AVENUE
LEAMINGTON, ONTARIO
N8H 2P2

LENADCO HOME FOR THE AGED
310 BRIDGE STREET WEST
NAPANEE, ONTARIO
K7R 2G4

MACASSA LODGE *
701 UPPER SHERMAN DRIVE
HAMILTON, ONTARIO
L8V 3M7

MAPLE VIEW LODGE *
ATHENS, ONTARIO
K0E 1B0

LA SALLE MANOR *
61 FAIRFAX CRESCENT
SCARBOROUGH, ONTARIO
M1L 1Z7

LEE MANOR
875 SIXTH STREET EAST
OWEN SOUND, ONTARIO
N4K 5W5

LINHAVEN
403 ONTARIO STREET
ST. CATHARINES, ONTARIO
L2N 1L5

MANITOULIN CENTENNIAL MANOR *
LITTLE CURRENT, ONTARIO
P0P 1K0

MARIANHILL
600 CECELIA STREET
PEMBROKE, ONTARIO
K8A 7Z3

MARIAN VILLA *
ST. JOSEPH'S HEALTH CENTRE OF LONDON
20 COLLEGE AVENUE
LONDON, ONTARIO
N6A 1Y1

MARKHAVEN
54 PARKWAY AVENUE
MARKHAM, ONTARIO
L3P 2G4

MARSHALL GOWLAND MANOR
1000 LONDON ROAD
SARNIA, ONTARIO
N7S 1N7

MARYCREST HOME *
200 ST. LUKE'S AVENUE
PETERBOROUGH, ONTARIO
K9H 1E7

MAXVILLE MANOR *
MECHANIC STREET
MAXVILLE, ONTARIO
K0C 1T0

McCORMICK HOME (THE)
230 VICTORIA STREET
LONDON, ONTARIO
N6A 2C2

McFARLAND (H.J.) MEMORIAL HOME
R.R. #2
PICTON, ONTARIO
K0K 2T0

METRO TORONTO LEGION VILLAGE
59 LAWSON ROAD
WEST HILL, ONTARIO
M1C 2J1

MIRAMICHI LODGE *
400 BELL STREET
PEMBROKE, ONTARIO
K8A 2K5

MON SHEONG
36 D'ARCY STREET
TORONTO, ONTARIO
M5T 1J7

MOUNT CARMEL HOME
78 YATES STREET
ST. CATHARINES, ONTARIO
L2R 5R9

NIPPONIA HOME
R.R. #3
BEAMSVILLE, ONTARIO
L0R 1B0

NISBET LODGE
740 PAPE AVENUE
TORONTO, ONTARIO
M4K 3S7

NITHVIEW HOME
200 BOULEE STREET
NEW HAMBURG, ONTARIO
N0B 2G0

NORTH CENTENNIAL MANOR
2 KIMBERLEY DRIVE
KAPUSKASING, ONTARIO
P5N 1L5

NORTHDALE MANOR
130 LAKESHORE ROAD
NEW LISKEARD, ONTARIO
P0J 1P0

NORTH LAMBTON REST HOME
39 MORRIS STREET
FOREST, ONTARIO
N0N 1J0

NORTHLAND MANOR
485 NORTHLAND AVENUE
PORT COLBORNE, ONTARIO
L3K 4B3

NORVIEW HOME *
SIMCOE, ONTARIO
N3Y 4L8

OAKVILLE SENIOR CITIZEN'S RESIDENCE
WEST TOWER & LINK BLOCK
2220-2222 LAKESHORE ROAD WEST
OAKVILLE, ONTARIO
L6L 5G5

PARKVIEW HOME
481 RUPERT AVENUE
STOUFFVILLE, ONTARIO
L4A 1T7

PARKWOOD MANOR
75 CARDINAL CRESCENT SOUTH
WATERLOO, ONTARIO
N2J 2E6

PATRICIA GARDENS
35 VAN HORNE STREET
DRYDEN, ONTARIO
P8N 2Z2

PEEL MANOR
525 MAIN STREET NORTH
BRAMPTON, ONTARIO
L6Y 1N9

PINECREST *
1220 VALLEY DRIVE
KENORA, ONTARIO
P9N 2W7

PINES (THE) *
PINE STREET
BRACEBRIDGE, ONTARIO
P0B 1C0

PINEWOOD COURT HOME *
445 JAMES STREET SOUTH
THUNDER BAY, ONTARIO
P7E 2V6

PIONEER MANOR *
960 NOTRE DAME AVENUE
SUDBURY, ONTARIO
P3A 2T4

PRESCOTT & RUSSELL RESIDENCE
1020 CARTIER BOULEVARD
HAWKESBURY, ONTARIO
K6A 1W7

PROVIDENCE MANOR
115 ORDNANCE STREET
KINGSTON, ONTARIO
K7K 1G7

PROVIDENCE VILLA *
3276 ST. CLAIR AVENUE EAST
SCARBOROUGH, ONTARIO
M1L 1W1

RAINYCREST
550 HOME STREET
FORT FRANCES, ONTARIO
P9A 3T2

RIDEAUCREST HOME *
362 MONTREAL STREET
KINGSTON, ONTARIO
K7K 3H6

RITZ LUTHERAN VILLA
R.R. #5
MITCHELL, ONTARIO
N0K 1N0

ROCKWOOD TERRACE
575 SADLER STREET
DURHAM, ONTARIO
N0G 1R0

ROTARY-LAUGHLEN CENTRE
110 EDWARD STREET
TORONTO, ONTARIO
M5G 2A5

SACRED HEART VILLA
COURTLAND, ONTARIO
N0J 1E0

SEVEN OAKS *
9 NEILSON ROAD
SCARBOROUGH, ONTARIO
M1M 2S3

SHALOM MANOR
12 BARTLETT AVENUE
GRIMSBY, ONTARIO
L3M 4N5

SHEPHERD LODGE
3760 SHEPPARD AVENUE EAST
AGINCOURT, ONTARIO
M1S 3E2

SHERIDAN PLACE
6 SHERIDAN PLACE
BRANTFORD, ONTARIO
N3T 2P6

SHERIDAN VILLA
2460 TRUSCOTT DRIVE
MISSISSAUGA, ONTARIO
L5J 3Z8

SIMCOE MANOR
MAIN STREET EAST
BEETON, ONTARIO
L0G 1A0

SOUTH CENTENNIAL MANOR
IROQUOIS FALLS, ONTARIO
P0K 1E0

SPRUCE LODGE *
643 WEST GORE STREET
STRATFORD, ONTARIO
N5A 1L4

ST. ANDREW'S RESIDENCE
99 PARK STREET WEST
CHATHAM, ONTARIO
N7M 3R5

ST. ANNE'S TOWER
661 DUFFERIN STREET
TORONTO, ONTARIO
M6K 2B3

ST. HILDA'S TOWERS
2339 DUFFERIN STREET
TORONTO, ONTARIO
M6E 4Z5

ST. JOSEPH'S HOME
325 EDINBURGH ROAD NORTH
GUELPH, ONTARIO
N1H 1E3

ST. JOSEPH'S VILLA
14 YORK STREET
CORNWALL, ONTARIO
K6J 3Y6

ST. JOSEPH'S VILLA *
56 GOVERNOR'S ROAD
DUNDAS, ONTARIO
L9H 5G7

ST. LAWRENCE LODGE
BROCKVILLE, ONTARIO
K6V 5W2

ST. LOUIS RESIDENCE *
879 CHEMIN PARC HIAWARTHA
GLOUCESTER, ONTARIO
K1C 2Z6

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD
CAMBRIDGE, ONTARIO
N3C 3T4

ST. PATRICK'S HOME *
2865 RIVERSIDE DRIVE
OTTAWA, ONTARIO
K1V 8N5

STRATHMERE LODGE *
ALBERT STREET WEST
STRATHROY, ONTARIO
N7G 3J3

SUNNYSIDE HOME *
247 FRANKLIN STREET NORTH
KITCHENER, ONTARIO
N2A 1Y5

SUN PARLOR HOME *
175 TALBOT STREET EAST
LEAMINGTON, ONTARIO
N8H 1L9

SUNSET HAVEN *
163 FIRST AVENUE
WELLAND, ONTARIO
L3C 1Y5

SUNSET MANOR *
RAGLAN STREET
COLLINGWOOD, ONTARIO
L9Y 3Z4

TECK PIONEER RESIDENCE
38 CHURCHILL DRIVE
KIRKLAND LAKE, ONTARIO
P2N 1V1

THAMESVIEW LODGE *
475 GRAND AVENUE WEST
CHATHAM, ONTARIO
N7L 4R5

THOMPSON HOUSE *
1 OVERLAND DRIVE
DON MILLS, ONTARIO
M3C 2C3

TRUE DAVIDSON ACRES
200 DAWES ROAD
TORONTO, ONTARIO
M4C 5M8

SUNSET LODGE
SALVATION ARMY
127 PETER STREET NORTH
ORILLIA, ONTARIO
L3V 4Z4

TABOR MANOR
1 TABOR DRIVE
ST. CATHARINES, ONTARIO
L2N 1V9

TERRACE LODGE
475 TALBOT STREET EAST
AYLMER, ONTARIO
N5N 3A5

THOMAS WILLIAMS HOME
57 WALNUT STREET
ST. THOMAS, ONTARIO
N5R 2Y7

TRILLIUM HOME
12 GRACE AVENUE
ORILLIA, ONTARIO
L3V 2K2

UNION VILLA
4300 HIGHWAY 7
UNIONVILLE, ONTARIO
L3R 1L8

UNITED MENNONITE HOME
45 SECOND STREET
VINELAND, ONTARIO
L0R 2C0

UPPER CANADA LODGE *
272 WELLINGTON ROAD
NIAGARA ON THE LAKE, ONTARIO
L0S 1J0

VALLEYVIEW *
CENTRE 29 ELYSIAN STREET
ST. THOMAS, ONTARIO
N5P 1R5

VERA M. DAVIS COMMUNITY CARE
80 ALLEN DRIVE
BOLTON, ONTARIO
L0P 1A0

VICTORIA MANOR
230 ANGELINE STREET SOUTH
LINDSAY, ONTARIO
K9V 4R2

VICTORIA RESIDENCE
190 STANLEY AVENUE
CHATHAM, ONTARIO
N7M 3J9

VILLA COLOMBO *
40 PLAYFAIR AVENUE
TORONTO, ONTARIO
M6B 2P9

VILLA MARIA
2856 RIVERSIDE DRIVE WEST
WINDSOR, ONTARIO
N9C 1A2

WELLINGTON TERRACE *
WELLINGTON DRIVE
ELORA, ONTARIO
N0B 1S0

WENTWORTH LODGE
41 SOUTH STREET WEST
DUNDAS, ONTARIO
L9H 4C4

WEXFORD (THE)
1860 LAWRENCE AVENUE EAST
SCARBOROUGH, ONTARIO
M1R 5B1

WOODINGFORD LODGE *
423 DEVONSHIRE AVENUE
WOODSTOCK, ONTARIO
N4S 7X6

YORK MANOR *
YOUNGE AND EAGLE STREETS
NEWMARKET, ONTARIO
L3Y 4W7

# APPENDIX B

# DETAILED METHODOLOGY

## 1.0 DETAILED METHODOLOGY

1.0 The following describes each of the steps taken to develop the questionnaires, implement the survey and analyse the resulting data for the Care Practices for Dementia Study. The Homes surveyed are listed in Appendix A.

### 1.1 Development of Questionnaires

There were two questionnaire developed: (1) a general questionnaire to collect information about the Homes' policies, procedures and practices in regard to residents with moderate or severe dementia; and (2) a special care unit questionnaire to collect the same type of information about special care units if the Home had one. Both questionnaires were divided into a number of sub-sections starting with a profile of the Home or unit, including the number of residents, beds and rooms; the characteristics of all residents in the Home (or unit) in terms of age and sex, marital status, assistance with activities of daily living, ambulation and cognitive impairment; the characteristics of residents with moderate or severe dementia in terms of the same descriptors; the location within the Home of residents with moderate or severe dementia; admission, transfer and discharge policies for residents with moderate or severe dementia; assessment and care planning; care strategies; in-house and outreach programs; staffing and training; volunteers and families; costs; environmental approaches and technological aids; and opinions about the value of separate units for residents with dementia.

Development of the general questionnaire and the questionnaire concerning special care units proceeded together, with the latter evolving as a variation of the general questionnaire. The steps taken to develop the questionnaires are described below.

#### 1.1.1 Site Visits

As part of the orientation period to the study, six site visits to different Homes in the province were conducted by the consulting team. The Homes were selected as representative of Homes in the province in terms of size (large and small), location (urban and rural), operation (municipal and charitable), length of time in operation and location of residents with dementia (separate care and integrated care). The purpose of the visits was to see how different Homes record information about their policies, procedures, residents, services and costs. The visits also gave an indication of which personnel would be best suited to complete various sections of the questionnaires.

A full day was spent at each Home and several activities were carried out. These included a number of interviews with staff and administration concerning the daily operations of the Home, its unique features and general practices; a review of existing documented policies including assessment procedures and forms, philosophy of care statements and other relevant documents; a review of costing procedures and amounts; and participation in a number of programs with staff and residents.

### 1.1.2 Focus Groups

Two full day focus groups were conducted in Toronto with a selected number of practitioners and personnel from a cross section of Homes for the Aged across the province. These individuals included nursing directors, adjuvants and social workers chosen in consultation with the client and the MCSS regional offices. The purpose of these focus groups was to clarify the issues of concern to personnel in Homes for the Aged, as an aid to questionnaire design, and to ascertain the availability of certain types of information. The groups were semi-structured and were carried out in two parts. The morning session involved a general discussion of a number of issues. The afternoon session consisted of small group discussion about each specific issue. Each group was responsible for summarizing their own discussions and presenting them to all participants at the end of the day.

### 1.1.3 Review of Related Studies and Key Informant Interviews

As part of the literature review for the study, a number of other Canadian and American studies were identified that had carried out surveys of various types of long term care facilities. Where possible, researchers were contacted and requests for relevant background material including questionnaires were made. Through interviews with these researchers, advantages and disadvantages of particular methods, questions etc, were discussed. Where appropriate, modified versions of questions used in related studies were utilized. For example, the definition and criteria of the different levels of cognitive impairment were developed and further refined for the purpose of this study after reviewing and discussing earlier work by McFadgeon with the principal researcher.[6]

### 1.1.4 Questionnaire Outline and Preliminary Drafts

After the above activities were completed, a detailed outline was developed for both the general questionnaire and special care unit questionnaire. These outlines were reviewed by the steering committee and suggestions were incorporated. Preliminary drafts of the general questionnaire and the special care unit questionnaire were then developed, based on the outlines, and sent to participants of the questionnaire experts workshop prior to the scheduled workshop.

### 1.1.5 Questionnaire Workshop

An all-day questionnaire workshop was held with representatives from MCSS and specialists in dementia. The draft questionnaires were further refined based on the results of this workshop and submitted to the Steering Committee for final review before the pre-test.

### 1.1.6 Questionnaire Worksheets

Two sets of worksheets were developed to assist Homes in summarizing the information on resident characteristics requested in the survey. One set pertained to all residents in the Home (or on the special care unit) and the other referred only to those residents classified by respondents as having moderate or severe dementia. The worksheets were designed so that respondents could record the required information by resident on a unit by unit basis. These figures were then aggregated by staff at the Homes and transferred to the questionnaire.

### 1.1.7 Pretest of All Survey Related Material

The survey was pretested in six Homes for the Aged. MCSS representatives helped in selecting these Homes to reflect different types of facilities: charitable and municipal; small and larger; rural and urban; Homes with and without a special care unit. All Homes in the pretest were asked to complete the survey using the worksheets as instructed in the questionnaire(s). Each Home was given a follow-up telephone call to discuss concerns and suggestions for improvements. The questionnaires and the worksheets were revised based on the pretests and submitted to the Ministry for final approval.

### 1.1.8 French Translation

A number of Homes for the Aged in the province are officially designated as French language facilities. All final survey-related materials were therefore translated into French by the Ministry's translation service. Two independent outside readers, one a practitioner in a Home, reviewed both the English and French version of the questionnaires to make sure that all terminology was the same and that the meaning of individual questions was identical in both languages.

## 1.2 Field Methods

The survey of Ontario's Homes for the Aged was conducted during the summer and fall of 1990. A survey package containing a covering letter, a general questionnaire, a special care unit questionnaire, accompanying sets of worksheets and attachments, and an addressed and stamped return envelope was mailed to all potential respondents. Respondents were provided with a "hotline" telephone number to call if they had any questions about the survey or required additional materials. This service was provided in English and French. A number of Homes called to request additional special care unit questionnaires, because their Home had more than one separate area of care. As well, a few Homes called to request additional time to complete the survey.

### 1.2.1 Field Monitoring of Returns

Homes were requested to return completed questionnaires about two weeks after they received the survey package. About one third of the respondents were able to comply. Most, however, required more time. The length of the questionnaire, complicated by staff shortages during the summer period, were the main factors accounting for the initial delay in returns. As questionnaires were returned, they were entered into a computerized status file. At the same time, each questionnaire was checked for completion and major omissions were followed up with respondents during the telephone interviews. Regular field reports were generated and response rates were calculated. Telephone follow-ups began after about two weeks.

### 1.2.2 Telephone Follow-ups

Two series of telephone follow-ups were completed, the first after about two weeks, and the second after about one month. The main purpose of these follow-ups was to contact Homes that had not responded and encourage their reply, as well as to answer any questions of concern. Most non-respondents were positive in their motivation to return the questionnaire(s). The main reason for not doing so was understaffing or not enough staff time to complete the survey. The two telephone reminders resulted in a very high final response rate (see 1.2.3).

Another purpose of the telephone follow-ups (as mentioned above) was to retrieve missing information from returned questionnaires. In some cases sections of the questionnaire were left blank by respondents because they did admit applicants to their Home with moderate or severe dementia. These were coded "not applicable".

### 1.2.3 Response Rate

The response to the survey was very high, with 133 of the 181 Homes returning completed questionnaires. (see Exhibit B1.2.3) Twelve of the Homes that returned questionnaires left some sections blank because they did not admit applicants with moderate or severe dementia. These Homes, however, had residents living the Home with dementia (contracted after admission) and thus did provide information on their overall resident profile. An additional fifteen Homes returned the questionnaire completely unanswered because they felt the study did not apply to them. These Homes were mostly residential facilities that said they did not admit persons with dementia and had no resident with dementia living in their Home. Only four Homes refused to complete the questionnaire, citing not enough staff resources as the main reason. The final response rate, adjusting for the not applicable Homes (those that were residential only) was 80.1% (133/166).

EXHIBIT B1.2.3

## ONTARIO HOMES FOR THE AGED CARE PRACTICES FOR DEMENTIA STUDY

## GENERAL SURVEY RESPONSE RATE

| | Number of Homes | Per Cent |
|---|---|---|
| **Status** | | |
| Total Number of Homes Surveyed | 181 | 100.0 |
| Number of Questionnaires Returned | 133 | 73.5 |
| Number of Questionnaires not Returned | 48 | 26.5 |
| **Reason for Non Response** | | |
| Not Applicable (no residents with dementia) | 15 | |
| Refusal | 4 | |
| Other | 29 | |

Response Rate (Total Returned/Total Applicable) 133/166 = 80.1%

The response to the Special Care Unit questionnaire was also very high. It was estimated by the Ministry that about half of the Homes in the province had an SCU. Completed SCU questionnaires were received from 67 Homes indicating a very high interest in the survey. Three Homes had more than one SCU - two Homes had 2 and one had 3 - resulting in a total of 71 questionnaires returned.

### 1.2.4 Response Bias

There was a concern that unless every Home responded to the survey, some response bias would appear. Two questions in particular, were of interest - whether there would be less response from smaller Homes with fewer staff resources, and if charitable Homes would be less likely to respond. In studying the response pattern, it was noted there was a slight tendency for municipally funded Homes to respond more readily than the charitable Homes. Just over half (51%) of the province's Homes are municipal Homes; about 60% of the Homes who responded to the survey were operated by the Municipality. There were no biases by size. About one third (34%) of the Homes for the Aged in Ontario have less than 100 beds. Exactly the same proportion responded to the survey.

## 1.3 Analysis of the Results

The information collected produced quantitative and qualitative data. A detailed analysis plan was submitted to the client outlining possible strategies for the analysis and presentation of these data.

### 1.3.1 Quantitative Analysis

Most of the survey information was quantitative. Numeric values assigned to the question responses were entered into a computer file and frequencies were produced using SPSSPC. The data were edited for out of range and inconsistent responses and final tables were tabulated. The information provided by each Home about their residents (age and gender distribution, marital status etc.) were aggregated across all responding Homes in order to present provincial trends. In some instances, mid points were calculated to demonstrate a "typical" or "average" response for all Homes. Both percentages and raw numbers were provided in the exhibits and text wherever feasible. A number of comparative or two way analyses were also explored and presented when differences were clearly found.

### 1.3.2 Qualitative Analysis and Workshops

A number of questions in the questionnaires were open-ended giving the respondents an opportunity to express their opinions about several issues. These responses were entered verbatim into a custom computer program designed for the purpose of sorting and analysing verbatim data (see Looker, Denton and Davis "Bridging the Gap: Incorporating Qualitative Data into Quantitative Analysis", Social Science 18, 313-330 (1989) for an explanation of this technique.) After the

verbatim data were entered, they were sorted and printed out question by question in preparation for a content analysis.

To assist the consultants in the task of defining major trends in the open ended responses, a final study workshop was held bringing together the same participants who earlier in the study process attended the focus groups. During the morning session of the workshop, participants were given an overview presentation of the major survey results. In the afternoon, participants formed small groups. Each group was given the task of summarizing the verbatims for one question (or a series of related questions). These summaries or "trends" were presented and discussed by all workshop participants at the end of the session.

## NOTES

[1]The median response or midpoint was calculated to represent the "average" for all Homes.

[2]Residential care is defined as "Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition." (1980, Ontario Ministry of Health, "Patient Care Classification by Types of Care" in Better Health for a Better Life.)

[3]Extended care is defined as "Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24-hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years." (1980, Ontario Ministry of Health, "Patient Care Classification by Types of Care" in Better Health for a Better Life.

[4]Respite care is defined as "planned or unplanned short term admission to a Long Term Care Facility that provides practical support to the primary caregiver(s) of a chronically dependant individual. Practical support is provided in terms of rendering education and guidance to the caregiver, assessing the needs of the caregiver and care recipient, developing and implementing a realistic plan of care that can be realized in the caregiver's normal care environment. Respite Care Services shall also provide linkages to external support systems which will enable the caregiver to continue in the role of caregiving." (Ontario Ministry of Community and Social Services, Operational Definition adapted for "A Respite Care Program Model")

[5]The survey contained a number of open-ended questions. The responses were entered verbatim into a custom computer program and sorted by question. These results were distributed and analyzed at a workshop (see Appendix B-1.3.2) with participants knowledgeable in care practices for dementia.

[6]S.L. MacFadgen. "The Care of Irrevisible Dementia Sufferers in the Toronto and Peel Regions". Canadian Journal on Aging 1987 (6):271-289.